PROTECTING TITLE X AND SAFEGUARDING QUALITY FAMILY PLANNING CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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PROTECTING TITLE X AND SAFEGUARDING QUALITY FAMILY PLANNING CARE

WEDNESDAY, JUNE 19, 2019

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:01 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, Hon. Diana DeGette (chairwoman of the subcommittee) presiding.

Members present: Representatives DeGette, Schakowsky, Kennedy, Ruiz, Kuster, Castor, Sarbanes, Tonko, Clarke, Pallone (ex officio), Guthrie (subcommittee ranking member), Burgess, Griffith, Brooks, Mullin, Duncan, and Walden (ex officio).

Also present: Representatives Luján, Veasey, Shimkus, Latta, Rodgers, Bilirakis, and Gianforte.

Staff present: Kevin Barstow, Chief Oversight Counsel; Jacquelyn Bolen, Professional Staff; Jesseca Boyer, Professional Staff Member; Jeffrey C. Carroll, Staff Director; Manmeet Dhindsa, Counsel; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Chris Knauer, Oversight Staff Director; Una Lee, Senior Health Counsel; Perry Lusk, GAO Detailee; Joe Orlando, Staff Assistant; Tim Robinson, Chief Counsel; Benjamin Tabor, Staff Assistant; C. J. Young, Press Secretary; Jennifer Barblan, Minority Chief Counsel, Oversight and Investigations; Mike Bloomquist, Minority Staff Director; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel, Health; Jordan Davis, Minority Senior Advisor; Margaret Tucker Fogarty, Minority Staff Assistant; Theresa Gambo, Minority Human Resources/Office Administrator; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; James Paluskiewicz, Minority Chief Counsel, Health; Brannon Rains, Minority Staff Assistant; and Natalie Sohn, Minority Counsel, Oversight and Investigations.

Ms. DEGETTE. The Subcommittee on Oversight and Investigations will now come to order.

Today, the Subcommittee on Oversight and Investigations is holding a hearing entitled Protecting Title X and Safeguarding Quality Family Planning Care. The purpose of the hearing is to examine the Federal Title X Family Planning Program.

The Chair now recognizes herself for the purposes of an opening statement.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Today, this subcommittee is holding the first congressional hearing in nearly 25 years on the Title X Family Planning Program. Established in 1970 with bipartisan support, Title X is the only Federal program solely dedicated to supporting family planning and related healthcare services, ensuring access to modern methods of birth control for low-income people and underserved communities.

Over the last half century, Title X has provided the gold standard of high-quality family planning and sexual healthcare to four million women and patients of all genders each year. Title X providers serve a racially and ethnically diverse population. Most patients are under 30 years old and, for many, Title X centers are the only source of their care.

The nearly 4,000 Title X health centers around the country come in all forms. They include local health departments, Planned Parenthoods, community health centers, and private and nonprofit organizations. My constituents, for example, can access Title X services at 15 different health centers in Denver, like the Stout Street Health Center and La Casa Family Health Center, all part of the Title X network supported by the grantee in my State, the Colorado Department of Public Health and the Environment.

These health centers provide a range of life-saving preventative health services: including breast and cervical cancer screening, HIV and other STI testing and treatment, and family planning and contraceptive information, supplies, and services. For 5 decades, regardless of the setting, patients seeking care at a Title X health center could depend on being treated with respect and dignity. Yet, this patient-centered care now faces an imminent threat. In March, the Trump administration finalized new regulations referred to by experts as the quote, "gag rule that poses significant threats to the Title X network and the patients' health and rights."

While anti-abortion ideology is fueling the administration's action, that motivation has no bearing on the Title X program. Using Title X to provide abortions has been and is currently statutorily prohibited. In fact, the administration cannot point to a single instance in the program's entire history, where Title X funds have been misapplied for this purpose.

Efforts to curb abortion providers' participation in Title X program is a solution in search of a problem. This rule is the administration's absurd effort to equate abortion referral as tantamount to the actual provision of abortion services. And as a result, the Government is inserting itself into the patient-provider relationship. The rule forbids health providers from giving complete information to patients on all of their pregnancy options. Even further, it would allow providers who oppose contraception, and are in favor of promoting other forms of family planning, to participate in the program.

The rule also threatens the ability of patients, especially young people, to have confidential conversations with their providers about their sexual health and well-being.

The gag rule would force providers to choose between offering limited information and care to their patients or to close their

doors. That seems like a dramatic and unfortunate choice to make. And what it would do is lead to a dramatic decline in women's and other patients' ability to received high quality and timely sexual and reproductive healthcare.

The long-term health consequences of limiting access to care could have dire consequences on critical public health priorities, disrupting, for example, the decline of historically low unintended pregnancy rates and a skyrocketing of HIV and other STI rates; the latter already at the highest level in recorded history.

According to the American Medical Association, the rule would, quote, "radically alter and decimate the Family Planning Assistance Program established by Title X with severe and irreparable public health consequences across the United States."

While the Title X gag rule is currently enjoined under injunctions, the Trump administration is doubling down on its commitment to dismantle this vital public health program, indicating last week that it has no intention of enforcing longstanding program requirements, like providing patients with complete family planning and pregnancy options. Should the Trump administration have its way, those who already face barriers to voluntary and non-coercive family planning and related healthcare, people of color, LGBTQ plus people, low-income people, young people, and people living in rural areas will bear the harshest consequences.

For five decades, Title X has relied on evidence of best practices to center and serve the needs of patients and communities. The Trump administration's agenda takes neither evidence nor patients into account in its attempts to dismantle the Title X network and to devastate access to high-quality family planning and sexual health in the United States.

I want to welcome all of our witnesses here, particularly, Dr. Foley. Thank you so much for coming this morning. We are going to also hear from some other experts.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Today, the Subcommittee is holding the first congressional hearing in nearly 25 years on the Title X family planning program.

Established in 1970 with bipartisan support, Title X is the only federal program solely dedicated to supporting family planning and related healthcare services, ensuring access to modern methods of birth control for low-income people and underserved communities.

Over the last half-century, Title X has provided the gold standard of high-quality family planning and sexual healthcare to four million women and patients of all genders each year.

Title X providers serve a racially and ethnically diverse population.

Most patients are under 30 years-old and, for many, Title X health centers are their only source of care.

The nearly 4,000 Title X health centers around the country come in all forms. They include local health departments, Planned Parenthoods, community health centers, and private and nonprofit organizations. My constituents, for instance, can access Title X services at 15 different health centers in the Denver area, such as Stout Street Health Center and La Casa Family Health Center, all part of the Title X network supported by the grantee in my state, the Colorado Department of Public Health and the Environment.

These health centers provide a range of lifesaving preventive health services, including breast and cervical cancer screening, HIV and other STI testing and treatment, and family planning and contraceptive information, supplies, and services.

For five decades, regardless of the setting, patients seeking care at a Title X health center could depend on being treated with respect and dignity.

Yet, this patient-centered care now faces an imminent threat. In March, the Trump Administration finalized new regulations, referred to by experts as the "Gag Rule," that poses significant threats to the Title X network and patients' health and rights.

While anti-abortion ideology is fueling the Administration's actions, this motivation has no bearing on the Title X program. Using Title X funds to provide abortions has been and is currently statutorily prohibited. In fact, the Administration cannot point to a single instance in the program's history where Title X funds have been misapplied for abortion.

Efforts to curb abortion providers' participation in the Title X program is a solution in search of a problem. This rule is the Administration's absurd effort to equate abortion referral as tantamount to the actual provision of abortion services.

And as a result, the government is inserting itself into the patient-provider relationship. The rule forbids health providers from giving complete information to patients on all of their pregnancy options. Even further, it would allow providers who oppose contraception and are in favor of promoting natural family planning methods and abstinence-before-marriage to participate in the program. The rule also threatens the ability of patients-especially young people-to have confidential conversations with their providers about sexual health and wellbeing.

The Gag Rule would force providers to choose between offering limited information and care to their patients or to close their doors.

This could lead to a dramatic decline in women's and other patients' ability to receive high-quality and timely sexual and reproductive healthcare.

The long-term health consequences of limiting access to care could have dire consequences on critical public health priorities-disrupting the decline of historically low unintended pregnancy rates and a skyrocketing of HIV and other STI rates, the latter already at the highest levels in recorded history.

According to the American Medical Association, the rule would, [Quote] "radically alter and decimate the family-planning assistance program established by Title X with severe and irreparable public health consequences across the United States."

While the Title X Gag Rule is currently enjoined under nationwide injunctions, the Trump Administration is doubling down on its commitment to dismantle this vital public health program-indicating last week that it has no intention of enforcing long-standing program requirements such as providing patients with complete family planning and pregnancy options.

Should the Trump Administration have its way, those who already face barriers to voluntary and noncoercive family planning and related healthcare-people of color, LGBTQ+people, low-income people, young people, and people living in rural areas-will bear the harshest consequences.

For five decades, Title X has relied on evidence of best practices to center and serve the needs of patients and communities. The Trump Administration's agenda takes neither evidence nor patients into account in its efforts to dismantle the Title X network and devastate access to high-quality family planning and sexual healthcare in the United States.

I look forward to hearing from Dr. Diane Foley, the Deputy Assistant Director for Population Affairs at the Department of Health and Human Services, regarding HHS's actions and their effects on healthcare in the United States.

Additionally, we will be hearing from experts who have repeatedly raised concerns about the consequences of these actions should the Trump Administration succeed in its efforts.

While the Administration may claim that the intention of the rule is to ensure compliance of Title X statutory requirements, it is yet another attempt to take away women's basic rights, and it will ultimately block millions of patients from high-quality family planning and preventive healthcare.

Ms. DEGETTE. I am now pleased to yield five minutes to the ranking member of the subcommittee, Mr. Guthrie.

OPENING STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF KENTUCKY

Mr. GUTHRIE. Thank you. Thank you, Chair DeGette, for holding this hearing and thank you for yielding the time.

For nearly 50 years, the Title X program has helped ensure that Americans have access to family planning methods and related preventative health services. The program has been especially important for low-income women. According to the most recent family planning annual report data, services were provided to more than four million individuals under the program in 2017.

The Title X program has helped a lot of men and women in my home State of Kentucky. In 2015, almost 50,000 individuals in Kentucky received services at a Title X clinic, including over 45,000 women. The Kentucky Cabinet for Health and Family Services oversees Title X-funded health centers across the Commonwealth. During the most recent funding cycle, HHS awarded the Kentucky Cabinet for Health and Family Services $5 million for fiscal year 2019.

Many Title X grantees work tirelessly to provide important services to families and adolescents. I am concerned, however, about the program integrity issues within the Title X program and that some guarantees might not always using funds in a way that is consistent with the statutory intent. Indeed, I joined other Members of Congress in writing a letter to HHS in April 2018 asking the Department to update the Title X regulations to ensure program integrity with respect to abortion.

When Congress created the Title X program in 1970, we drew a line between family planning and abortion. The Title X statute specifically states that, and I quote from the statute, "none of the funds appropriated under this Title shall be used in programs where abortion is a method of family planning," unquote.

Unfortunately, the regulations issued by the Clinton administration that have governed the Title X program for nearly two decades have blurred the line between family planning and abortion by requiring Title X grantees to refer women for abortion and allowing Title X clinics to co-locate within abortion clinics.

The Trump administration took an important step toward improving program integrity and ensuring that Title X funds are used consistently with the statutory intent when the administration issued the Protect Life Rule.

Among other things, the Protect Life Rule helps ensure compliance with the statutory requirement for the Title X program that none of the funds appropriated for Title X may be used in programs where abortion is a method of family planning.

While my colleagues on the other side of the aisle are likely to express outrage at the Protect Life Rule, I would like to remind them that these changes make the regulatory framework governing the Title X program nearly identical to the regulatory framework created by the Reagan Era regulations for the Title X program.

Just like there have been lawsuits filed against the Protect Life Rule, the Reagan Era regulations were also challenged in court. In 1991, the Supreme Court in Russ v. Sullivan upheld the Reagan Era regulations and said "they were permissible construction of the Title X statute."

One of the concerns I have heard about the Protect Life Rule is that it will harm women's access to contraception under the Title X program. The Title X statutory language is clear and requires the Title X family planning projects, "provide a broad range of ac-

ceptable and effective family planning methods and related preventative health services." The Protect Life Rule includes this exact language and the most recent funding announcement for the Title X program directly states that each Title X project must include a broad range of acceptable and effective methods of family planning, including contraception. Moreover, the funding announcement notes that a broad range does not necessarily need to include all categories of services but should include hormonal methods, since these are requested most frequently by clients among the methods shown to be the most effective in preventing pregnancy.

Given this language in the funding announcement, I hope to hear more today about how, if at all, HHS expects access to contraception through the Title X program to change when the Protect Life Rule is fully implemented.

I am also looking forward to hearing from HHS about how they felt changes to the Title X program will help ensure program integrity with respect to abortion, where necessary.

I want to thank all the witnesses for being here today.

And before I yield back, I would like to do a unanimous consent to enter the following items into the record: An April 30, 2018 letter to Secretary Azar signed by myself and more than 150 Members of Congress; a July 10 letter to Secretary Azar by 140 Members of Congress, including myself; and an April 3, 2019 letter to Secretary Azar signed by 100 Members, including myself; and a June 18, 2019 letter to Representative Bilirakis from the Family Research Council.

Ms. DEGETTE. Without objection, the documents will be entered.

[The information appears at the conclusion of the hearing.]

Mr. GUTHRIE. And I yield back.

[The prepared statement of Mr. Guthrie follows:]

PREPARED STATEMENT OF HON. BRETT GUTHRIE

Thank you, Chair DeGette, for holding this important hearing.

For nearly 50 years, the Title X program has helped ensure that Americans have access to family planning methods and related preventive health services. The program has been especially important for low-income women. According to the most recent Family Planning Annual Report data, services were provided to more than 4 million individuals under the program in 2017.

The Title X program has helped a lot of men and women in my home state of Kentucky. In 2015, almost 50 thousand individuals in Kentucky received services at a Title X clinic, which included over 45 thousand women. The Kentucky Cabinet for Health and Family Services oversees Title X-funded health centers across the commonwealth. During the most recent funding cycle, HHS awarded the Kentucky Cabinet for Health and Family Services 5 million dollars for fiscal year 2019.

Many Title X grantees work tirelessly to provide important services to families and adolescents. I am concerned, however, about program integrity issues within the Title X program and that some grantees may not be always using funds in a way that is consistent with the statutory intent. Indeed, I joined other Members of Congress in writing a letter to HHS in April 2018 asking the Department to update the Title X regulations to ensure program integrity with respect to abortion.

When Congress created the Title X program in 1970, we drew a line between family planning and abortion. The Title X statute specifically states that, and I quote, "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." Unfortunately, the regulations issued by the Clinton Administration that have governed the Title X program for nearly two decades have blurred the line between family planning and abortion by requiring Title X grantees to refer women for abortion and allowing Title X clinics to co-locate with abortion clinics.

The Trump Administration took an important step toward improving program integrity and ensuring that Title X funds are used consistently with the statutory intent when the Administration issued the Protect Life Rule. Among other things, the Protect Life Rule helps ensure compliance with the statutory requirement for the Title X program that none of the funds appropriated for Title X may be used in programs where abortion is a method of family planning.

While my colleagues on the other side of the aisle are likely to express outrage at the Protect Life Rule, I'd like to remind them that these changes make the regulatory framework governing the Title X program nearly identical to the regulatory framework created by Reagan era regulations for the Title X program.

Just like there have been lawsuits filed against the Protect Life Rule, the Reagan-era regulations were also challenged in court. In 1991, the Supreme Court in Rust v. Sullivan upheld the Reagan-era regulations and said that they were a permissible construction of the Title X statute.

One of the concerns I have heard about the Protect Life Rule is that it will harm women's access to contraception under the Title X program. The Title X statutory language is clear and requires that Title X family planning projects "provide a broad range of acceptable and effective family planning methods and related preventive health services." The Protect Life Rule includes this exact language, and the most recent funding announcement for the Title X program directly states that that each Title X project must include a broad range of acceptable and effective methods of family planning, including contraception. Moreover, the funding announcement notes that a "broad range" does not necessarily need to include all categories of services, but should include hormonal methods since these are requested most frequently by clients and among the methods shown to be the most effective in preventing pregnancy.

Given this language in the funding announcement, I hope to hear more today about how, if at all, HHS expects access to contraception through the Title X program to change when the Protect Life Rule is fully implemented. I am also looking forward to hearing more from HHS about why they felt changes to the Title X program that will help ensure program integrity with respect to abortion were necessary.

I want to thank all of the witnesses for being here today.

Ms. DEGETTE. The Chair now recognizes the ranking member of the full committee—I am sorry—the chairman of the full committee, Mr. Pallone, for five minutes for purposes of an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairwoman DeGette.

Today's hearing is the latest step in this committee's ongoing work to hold the Trump administration accountable for the dramatic changes it has proposed to our nation's Title X Family Planning Program. The administration's proposal not only threatens the purpose of Title X but the health of every low-income woman and family that the program is intended to serve.

Title X is a competitive grant program that allows the providers who are best equipped to meet the unique health needs of a community participate in the program. And this is how the program is designed and it is a hallmark for why the program has been successful.

Take my home State, for example. The New Jersey Family Planning League operates a network of Title X health centers serving nearly 100,000 patients a year, including locations in my district operated by Planned Parenthood. Yet, this administration is promoting harmful changes to the Title X program because this diverse and community-driven network of health centers includes

abortion providers who offer abortion services with non-Title X and non-federal funds.

Prior to the most recent round of project awards, 40 percent of all women served by Title X-funded health centers were served at Planned Parenthood sites. By targeting entities that provide comprehensive reproductive healthcare services, the administration's Title X gag rule stands to destroy the intent of the Title X program and that is to serve those with limited means to access high-quality family planning and related healthcare. By denying funding to these providers, the Trump administration is making it harder for low-income women and families to get the health information and care that they need.

In fact in his ruling preventing the administration from implementing its Title X Rule, Judge McShane with the U.S. District Court of Oregon stated, and I am quoting, "the final rule would create a class of women who are barred from receiving care consistent with accepted and established professional medical standards." Judge McShane went on to say that, if implemented, the final rule will, and I am quoting again, "result in less contraceptive services, more unintended pregnancies, less early breast cancer detection, less screening for cervical cancer, less HIV screening, and less testing for sexually transmitted disease." HHS' response to these negative health outcomes is one of silence and indifference.

Now that is damning, in my opinion, and unfortunately, indifference is far too common with the Trump administration. Under President Trump and Secretary Azar's leadership, HHS has repeatedly promoted policies, practices, and proposals intent on sabotaging healthcare in our nation and ripping healthcare away from millions of Americans. And this administration is comfortable putting its divisive ideology over the needs of people and families.

So this committee has repeatedly sought answers on the administration's ongoing threats to Title X programs and, to date, the responses have been woefully inadequate from nearly termination of Title X projects, to funding announcements that undermine the value of quality family planning providers, to the new rule that would gag providers and limit patients access to information and care. The Trump administration has been intent on replacing providers' and patients' judgment with their own.

And for nearly 50 years, when you walked in the door of a Title X health center, you could trust that every staff member would treat you with dignity and respect and that you would receive complete and accurate medical information. But the Trump administration's actions undermine that longstanding commitment, sabotaging not just the Title X program and its patients but access to high-quality family planning and related healthcare across this country.

As long as the Trump administration continues its efforts to undermine healthcare for millions of Americans, this committee will continue to hold it accountable.

I don't know if anyone wants my minute or so. If not, I will yield back, Madam Chair.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Today's hearing is the latest step in this Committee's ongoing work to hold the Trump Administration accountable for the dramatic changes it has proposed to our nation's Title X family planning program. The Administration's proposal not only threatens the purpose of Title X, but the health of every low-income woman and family that the program is intended to serve.

Title X is a competitive grant program that allows the providers who are best equipped to meet the unique health needs of a community to participate in the program. This is how the program was designed, and is a hallmark for why the program has been successful.

Take my home state for example, the New Jersey Family Planning League operates a network of Title X health centers serving nearly 100,000 patients a year, including one site in my district, Planned Parenthood of Northern, Central and Southern New Jersey.

Yet, this Administration is promoting harmful changes to the Title X program because this diverse and community driven network of health centers includes abortion providers, namely Planned Parenthood, who offer abortion services with non-Title X and non-federal funds. Prior to the most recent round of project awards, 40 percent of all of women served by Title X-funded health centers were served at Planned Parenthood sites.

By targeting entities that provide comprehensive reproductive healthcare services, the Administration's Title X Gag Rule stands to destroy the intent of the Title X program-to serve those with limited means to access high-quality family planning and related healthcare. By denying funding to these providers, the Trump Administration is making it harder for low-income women and families to get the health information and care they need.

In fact, in his ruling preventing the Administration from implementing its Title X rule, Judge McShane with the U.S. District Court of Oregon stated: [and I'm quoting] "The Final Rule would create a class of women who are barred from receiving care consistent with accepted and established professional medical standards."

Judge McShane went on to say that if implemented, the final rule will [and I'm quoting again]."result in less contraceptive services, more unintended pregnancies, less early breast cancer detection, less screening for cervical cancer, less HIV screening, and less testing for sexually transmitted disease. HHS's response to these negative health outcomes is one of silence and indifference."

That's damning, and unfortunately, indifference is far too common with this Administration. Under President Trump and Secretary Azar's leadership, HHS has repeatedly promoted policies, practices, and proposals intent on sabotaging healthcare in our nation and ripping healthcare away from millions of Americans.

This Administration is comfortable putting its divisive ideology over the needs of people and families.

This Committee has repeatedly sought answers on the Administration's ongoing threats to the Title X program, and to date the responses have been woefully inadequate. From the early termination of Title X projects, to funding announcements that undermined the value of quality family planning providers, to the new rule that would gag providers and limit patients' access to information and care, this Administration has been intent on replacing providers' and patients' judgement with their own.

For nearly 50 years, when you walked in the door of a Title X health center, you could trust that every staff member would treat you with dignity and respect, and that you would receive complete and accurate medical information. The Trump Administration's actionsundermine that long-standing commitment, sabotaging not just the Title X program and its patients, but access to high-quality family planning and related healthcare across the country.

As long as the Trump Administration continues its efforts to undermine healthcare for millions of Americans, this Committee will continue to hold it accountable.

Thank you.

Ms. DEGETTE. The gentleman yields back.

The Chair now recognizes the ranking member of the full committee, Mr. Walden for five minutes for an opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Thank you, Madam Chair, and good morning to our guests and our witnesses. We appreciate you all being here today.

Title X Family Planning programs played a critical role in ensuring access to a broad range of family planning and preventive health services for nearly 50 years. While the Title X program is the only Federal program dedicated solely to supporting the delivery of family planning and related preventative healthcare, there are many different Federal funding sources for family planning services. Some of these other important programs include: Medicaid, the Health Center program, Maternal and Children Health Block Grants, and Temporary Assistance for Needy Families. In fact, in fiscal year 2015, Medicaid accounted for 75 percent of public family planning expenditures in the United States; Title X accounted for about 10 percent.

Although the Title X program only accounts for a very small percentage of public funding expenditures for family planning services, it is an important program, especially for low-income women across the country. And according to the most recent family planning annual report data, Title X-funded sites in my State of Oregon served 44,815 Oregonians in 2017, including 41,952 women. Of the Oregonians that received Title X services in 2017, nearly 42,000 had incomes at or below 250 percent of the Federal poverty level. The types of services that Oregonians received through the Title X program include but are not limited to family planning services, such as: education, counseling, contraception, and clinical services, STD testing and treatment, and HIV testing.

I was pleased to see that the HHS awarded the Oregon Health Authority Reproductive Health Program more than $3 million in Title X funds for fiscal year 2019. OHA sub-grantees include community health departments and community health centers across my district. Community health centers are an important component of the Title X network because these centers provide comprehensive primary care for entire families.

Given the important services Americans receive under the Title X program, I am glad that we have HHS here today to learn more about the recent actions relating to the Title X program and how the administration thinks that these changes will impact the program, and the services offered under the programs. Dr. Foley, we are glad you are here.

When Congress created the Title X program, Congress explicitly stated, "none of the funds appropriated under the Title shall be used in programs where abortion is a method of family planning." That is the statute. It is important that Federal programs are implemented and operated in ways that are consistent with the law. And I am, therefore, interested in knowing about any challenges HHS has faced in overseeing the Title X program and why the agency decided to make the recent changes to the Title X program.

Many patients and physicians have come to rely on the Title X program since it was created in 1970, which is why it is critical that changes to the program do not harm patient access to the important services that Congress intended be provided under this program. I have heard concerns from some groups, such as the Na-

tional Association of Community Health Centers that the recent changes to the program could potentially harm access to care for some individuals. So, I hope you will be able to address that issue as well today, Dr. Foley.

While major focus of the Title X program is to right grants to clinical service providers, the program also supports other priorities and initiatives at HHS, such as HHS' initiative to identify and provide solutions to reduce substance abuse disorders and assisting the Government's response to infectious disease outbreaks that impact the ability of individuals to achieve healthy pregnancies, viruses like Zika, among others.

While these elements of the program are not likely to be a focus of our conversation today, and I understand that, I am interested in hearing more about them and whether there are any issues that affect family planning projects that currently are not addressed by the Title X program.

And Madam Chair, as you know, we have a subcommittee hearing going on upstairs on important pipeline safety legislation concurrent with this one, so I will be going back and forth as the ranking member.

But I appreciate all the witnesses today and the fact that we are having this hearing, and look forward to the testimony of our witnesses and the opportunity to ask a few questions later on.

With that, Madam Chair, I will yield back the remaining 44 seconds.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Chair DeGette, for holding this hearing.

The Title X family planning program has played a critical role in ensuring access to a broad range of family planning and preventive health services for nearly 50 years. While the Title X program is the only federal program dedicated solely to supporting the delivery of family planning and related preventive healthcare, there are many different federal funding sources for family planning services. Some of these other important programs include Medicaid, the Health Center Program, Maternal and Child Health Block Grants, and Temporary Assistance for Needy Families. In Fiscal Year 2015, Medicaid accounted for about 75 percent of public family planning expenditures in the United States while Title X accounted for about 10 percent.

Although the Title X program only accounts for a small percentage of the public funding expenditures for family planning services, it is an important program, especially for low-income women across the country. According to the most recent Family Planning Annual Report data, Title X-funded sites in Oregon served 44,815 Oregonians in 2017, including 41,952 women. Of the Oregonians that received Title X services in 2017, about 42,000 had incomes at or below 250 percent of the federal poverty level. The types of services that Oregonians received through the Title X program include, but are not limited to, family planning services such as education, counseling, contraception, and clinical services, STD testing and treatment, and HIV testing.

I was pleased to see that HHS awarded the Oregon Health Authority Reproductive Health Program over 3 million dollars in Title X funds for Fiscal Year 2019. OHA's sub-grantees include community health departments and community health centers across my district. Community health centers are an important component of the Title X network-these centers provide comprehensive primary care for the entire family.

Given the important services Americans receive under the Title X program, I am glad that we have HHS here today to learn more about the recent actions relating to the Title X program and how they think these changes will impact the program and the services offered under the program.

When Congress created the Title X program, Congress explicitly stated that, and I quote, "none of the funds appropriated under the title shall be used in programs where abortion is a method of family planning." It is important that federal programs are implemented and operated in ways that are consistent with the statutory language, and I am therefore interested in knowing about any challenges HHS has faced in overseeing the Title X program and why they decided to make the recent changes to the Title X program.

Many patients and physicians have come to rely on the Title X program since it was created in 1970, which is why it is critical that changes to the program do not harm patient access to the important services that Congress intended to be provided under the program. I've heard concerns from some groups such as the National Association of Community Health Centers that the recent changes to the program could potentially harm access to care for some individuals, and I hope that HHS can address some of those concerns today.

While a major focus of the Title X program is to provide grants to clinical service providers, the program also supports other priorities and initiatives at HHS such as HHS' initiative to identify and provide solutions to reduce substance abuse disorders and assisting the government's response to infectious disease outbreaks that impact the ability of individuals to achieve healthy pregnancies, like the Zika virus. While these elements of the program are not likely to be a focus of our conversation today, I am interested in hearing more about them and whether there are any issues that affect family planning projects that currently are not addressed by the Title X program.

Thank you, and I yield back.

Ms. DEGETTE. The gentleman yields back.

I would ask unanimous consent that the Members' written opening statements be made a part of the records. Without objection, so ordered.

I would now like to introduce our first witness for today's hearing, Dr. Diane Foley, who is the Deputy Assistant Secretary, Office of Population Affairs, with the Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services.

And Dr. Foley, I am particularly happy to welcome you because you are from my home State of Colorado. So welcome.

I am sure you know that the subcommittee is holding an investigative hearing. And when doing so, has had the practice of taking testimony under oath. Do you have any objections to testifying under oath today?

Dr. FOLEY. No, I do not.

Ms. DEGETTE. The witness has responded no. The Chair then advises you that under the rules of the House and the rules of the Committee, you are entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

Dr. FOLEY. Yes.

Ms. DEGETTE. And if you could, introduce that counsel, please.

Dr. FOLEY. I am going to ask them to introduce themselves. They are here with us.

Ms. DEGETTE. Thank you.

Mr. KEVENEY. Sean Keveney with the Office of General Counsel, HHS.

Ms. DEGETTE. Thank you. So now, if you would please, Doctor, rise and raise your right hand so you may be sworn in.

[Witness sworn.]

Ms. DEGETTE. Let the record reflect the witness responded yes. You may be seated.

Dr. Foley, you are now under oath and subject to the penalties set forth in Title 18 Section 1001 of the U.S. Code. And I will now recognize you for a 5-minute summary of your written statement.

In front of you is a microphone and a series of lights. The light turns yellow when you have a minute left and it turns red to indicate that your time has come to an end.

And you are now recognized for five minutes.

STATEMENT OF DIANE FOLEY, M.D.

Dr. FOLEY. Thank you.

Chair DeGette, Ranking Member Guthrie, and members of the subcommittee, thank you for this invitation to appear before you on behalf of the Department of Health and Human Services. I welcome the opportunity to discuss the Title X Rule and the Title X Family Planning Program.

I am the Deputy Assistant Secretary for Population Affairs under the Office of the Assistant Secretary for Health. Over the past year, it has been my privilege to work with professional career staff, grantees, and health professionals who make it their mission to ensure that Title X funds are used to provide quality family planning services to the adolescents, women, and men who need them.

My professional career has been spent practicing pediatrics with a focus on adolescent health. While chief resident in pediatrics, I was a Title X provider in one of the first school-based health clinics in Indiana. After residency, I founded and served as medical director of a pediatric practice and spent the next 17 years establishing one of the largest private pediatric practices in Central Indiana.

In 2004, I relocated to Colorado and my practice was limited, at that time, to adolescent gynecology. At the same time, I provided direction to a non-profit organization and implemented a federally-funded sex education program in the Colorado Springs area. Part of that direction included developing a program to teach adolescents about sexually transmitted infections and contraception. Most recently, I practiced pediatrics in a rural critical access hospital in south-eastern Colorado.

Title X of the Public Health Service Act was enacted in 1970 and authorized the establishment and operation of voluntary family planning projects, offering a broad range of acceptable and effective family planning methods and services, including natural family planning methods, infertility services, and services for adolescents.

The Title X program serves close to four million clients every year in over 3,900 clinic sites. Currently, there are 90 grantees using Title X funds, including State Health Departments, family planning councils, Federally Qualified Health Clinics, and private non-profit entities. These grantees are located in all 50 States, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and the six Pacific jurisdictions. I am proud to direct the efforts of dedicated career staff who are committed to promoting health across the reproductive life span.

The 2019 Title X Rule ensures program integrity and compliance with statutory provisions. And in particular, the statutory prohibition on funding programs where abortion is a method of family planning. This rule will promote quality family planning services to clients, while ensuring that taxpayer dollars are spent according to the original intent of Congress. This rule provides for clear financial and physical separation between Title X and non-Title X activities. This will assist grantees and prevent reporting defi-

ciencies. It will make it clear to clients and the general public that Title X funds are being used according to the law. This rule protects the provider-client relationship. It is not a gag rule. Health professionals are free to provide non-directive pregnancy counseling, including counseling on abortion. This rule protects the conscious rights of health professionals, including Title X providers, grantees and applicants, by eliminating the requirement to counsel about and refer for abortion. This rule ensures, consistent with and eliminates any confusion about, the Department's longstanding policy to respect these rights. The rule does not prohibit health professionals from providing medically-necessary information to clients. In fact, by requiring referral for those conditions where treatment is medically necessary, this rule ensures quality healthcare for women.

In line with statutory requirements, referral for abortion as a method of family planning is prohibited. However, referral for abortion is permitted in cases where there are emergency medical situations. This rule will protect women and children by ensuring that every Title X clinic has a plan to report abuse, rape, incest, as well as intimate partner violence, and sex trafficking. This is in accordance with the individual State laws. It requires that all Title X clinics provide annual training for staff, not only to recognize those clients who have been or are being abused but also to provide appropriate follow-up for them.

This rule provides guidance to grantees to encourage family participation in the decision of minors seeking family planning services. It will advance meaningful family communication, providing important support to adolescents as they make these decisions. By expanding criteria for grant applications, this rule will increase competition and encourage innovative approaches to unserved populations. First and foremost, the revisions to the Title X Rule promote the well-being of individuals, families, and communities across the nation.

Thank you once again for having me here today. I look forward to discussing how this rule will ensure the Title X program remains in compliance but also fulfills the original purpose of Congress so that more adolescents, women, and men are able to achieve their family planning goals.

[The prepared statement of Dr. Foley follows:]

Testimony of

Diane Foley, MD, FAAP
Deputy Assistant Secretary
Office of Population Affairs
Director
Office of Adolescent Health
U.S. Department of Health and Human Services

Before the

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives
June 19, 2019

Chair DeGette, Ranking Member Guthrie, and Members of the Subcommittee, it is my honor to appear on behalf of the Department of Health and Human Services (HHS).

I was appointed as Deputy Assistant Secretary for Population Affairs (OPA) in May 2018 and also became the Director of the Office of Adolescent Health (OAH) in June 2019. It has been my privilege to work alongside the many dedicated, professional career staff who make it their mission to ensure that Title X funds are used to provide quality family planning methods and services to the adolescents, women, and men who need them. My professional career has been spent in the clinical practice of pediatrics with a focus on adolescent health. While chief resident in pediatrics, I was a Title X provider in one of the first school-based teen health centers located in a large high school in Indianapolis, Indiana. After residency, I founded and served as the medical director of Northpoint Pediatrics and spent the next seventeen years establishing one of the largest pediatric practices in central Indiana. During this same period, I also served as a pediatric clinical instructor for the pediatric and family practice residency programs at the Indiana University School of Medicine training young physicians in the areas of general pediatrics, adolescent gynecology, prevention and treatment of sexually transmitted diseases, healthy family formation, and global health.

In 2004, I relocated to Colorado where I provided direction to a private non-profit organization and implemented a federally funded sex education program in 26 high schools in the Colorado Springs area. Part of that direction included developing a medically accurate curriculum about sexually transmitted infections and contraception for middle and high school students that was incorporated into the health curricula in 5 school districts. Most recently, I was a part-time pediatrician at a certified Centers for Medicare & Medicaid Services Critical Access Hospital in Lamar, Colorado. At the same time, I served as Director of Medical Ministries for Global Partners of the Wesleyan Church, where my responsibilities included oversight of mission hospitals in Sierra Leone, Zambia, and Haiti.

Title X is the only federal program dedicated solely to the provision of family planning and related preventive services, with priority given to those from low income families. Established in 1970, by Public Law 91–572, 84 Stat. 1504, the program provides funding "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)."[1] OPA administers the Title X program and serves as the focal point to advise the Secretary of HHS and the Assistant Secretary for Health (ASH) on a wide range of reproductive health topics. One of my priorities as the Deputy Assistant Secretary of OPA is to make sure that comprehensive family planning and related preventive health services under the Public Health Service Act are provided to those who need them.

The regulations governing the Title X program have not been substantially updated since 2000. Since then, the need to clarify and ensure compliance has only increased. Presently, the Title X program funds 90 public health departments and community health, family planning, and other

[1] Public Health Service (PHS) Act § 1001(a), 42 U.S.C. § 300(a).

private nonprofit agencies through grants. Those grants support delivery of family planning services at almost 4,000 service sites.[2] As a program designed to provide voluntary family planning services, the Title X program helps women, men and adolescents make healthy and fully informed decisions about starting a family and determining the number and spacing of children.

Recognizing that the 2019 Final Rule is the active subject of litigation, this testimony summarizes how the 2019 Final Rule will ensure compliance with, and enhance implementation of, the statutory requirements of Title X if ultimately upheld by the courts.[3] The Title X program serves approximately 4 million clients every year. The Final Rule will ensure that grants and contracts awarded under this program fully comply with the statutory program integrity requirements, thereby fulfilling the purpose of Title X, so that more women, men, and adolescents can receive services that help them consider and achieve both their short-term and long-term family planning needs.

There are six important pillars within the 2019 Title X Final Rule.

First, the primary purpose of the Final Rule is to **ensure program integrity, consistency and compliance** with the ***original statutory intent of*** Title X.

From the start, Congress was clear that Title X funds cannot be used to support abortion. Since enactment, Title X has contained the following prohibition at section 1008: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."[4]

Consistent with the statutory prohibition, the Department seeks to ensure that funds are neither directly nor indirectly used where abortion is a method of family planning. Therefore, the 2019 Final Rule provides for clear financial and physical separation between Title X services and the use of abortion as a method of family planning to reduce any confusion between the two.

The Final Rule protects against the co-mingling of Title X resources with non-Title X resources or programs. Physical and enhanced financial separation address several concerns of the Department. They address concerns over the fungibility of Title X resources and the potential use of Title X resources to support programs where, among other things, abortion is a method of family planning. They address the potential for ambiguity between approved Title X activities and non-Title X activities that support abortion as a method of family planning and the significant risk for public confusion over the scope of Title X services. And they address the concern that Title X resources could facilitate the development of, and ongoing use of, infrastructure for non-Title X activities, especially for abortion as a method of family planning.

The Department seeks to protect Title X (and Title X funds) as the discrete, domestic, Federal grant program focused solely on the provision of cost-effective family planning methods and

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[2] Fowler et al., *Family Planning Annual Report: 2017 National Summary* (Aug. 2018), *https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.*

[3] PHS Act § 1006; 42 U.S.C. § 300a-4.

[4] PHS Act § 1008, 42 U.S.C. § 300a-6.

services. The Final Rule thus requires physical and financial separation to protect the statutory integrity of the Title X program, to eliminate the risk of co-mingling or misuse of Title X funds.[5]

It is important to remember that the Department promulgated substantially similar regulations in 1988. 53 Fed. Reg. 2922 (1988). Those regulations "require[d] a ban on ... referral ... and advocacy [of abortion] within the Title X project" and "mandate[d] that Title X programs be organized so that they are physically and financially separate from [abortion-related] activities." *Rust v. Sullivan,* 500 U.S. 173, 184, 188 (1991); *see also* 53 Fed. Reg. 2922 (1988). The Supreme Court upheld those regulations in *Rust,* concluding that they were lawful, on statutory and Constitutional grounds. *Id.* at 184, 192–203.

The 2019 Final Rule places a high priority on **preserving the provider/client relationship**, thereby promoting optimal health for every Title X client. To preserve open communication between the client and the provider, the regulation permits, but does not require, nondirective pregnancy counseling, including nondirective counseling on abortion. Consistent with the statutory requirement that no funds may be used where abortion is a method of family planning, this regulation affirmatively prohibits referral for abortion as a method of family planning. Those changes ensure compliance with Title X's statutory purpose and ensure consistency with federal health-care conscience laws (Church,[6] Coats/Snowe,[7] and Weldon Amendments[8]), while still protecting the provider/client relationship.

The Final Rule ***does not*** preclude provision of medically necessary information. In requiring referrals for those conditions where treatment is deemed medically necessary, the Final Rule ensures quality care for all clients. The 2019 Final Rule requires medically necessary referrals, such as referrals for prenatal care for the health of the mother as well as the unborn baby. If a pregnant client presents with an emergent medical condition, such that emergency care is required, the Title X project is also required to refer the client immediately to an appropriate provider of emergency medical services under the Final Rule. Title X projects *may* refer for abortion for emergency care reasons, but may not refer for abortion as a method of family

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[5] Compliance with Statutory Program Integrity Requirements, 84 FR 7714, 7715 (2019).

[6] The Church Amendments, among other things, prohibit certain HHS grantees from discriminating in the employment of, or the extension of staff privileges to, any health care professional because they refused, because of their religious beliefs or moral convictions, to perform or assist in the performance of any lawful sterilization or abortion procedures. The Church Amendments also prohibit individuals from being required to perform or assist in the performance of any health service program or research activity funded in whole or in part under a program administered by the Secretary contrary to their religious beliefs or moral convictions. *See* 42 U.S.C. § 300a–7.

[7] The Coats-Snowe Amendment bars the federal government and any State or local government that receives federal financial assistance from discriminating against a health care entity, as that term is defined in the Amendment, who refuses, among other things, to provide referrals for induced abortions. *See* 42 U.S.C. § 238n (a).

[8] The Weldon Amendment was added to the annual 2005 health spending bill and has been included in subsequent appropriations bills. *See* Consolidated Appropriations Act, 2018, Public Law 115–141, Div. H, sec. 507(d), 132 Stat. 348, 764; Consolidated Appropriations Act, 2017, Public Law 115–31, Div. 507(d), 131 Stat. 135, 562. The Weldon Amendment bars the use of appropriated funds on a federal agency or programs, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not, among other things, refer for abortions. HHS's longstanding policy has been, and continues to be, to not apply or enforce the provisions set forth in 42 C.F.R. § 59.5(a)(5), promulgated in 65 Fed. Reg. 41,270 (July 3, 2000), as those provisions relate to abortion referrals, to Title X providers with religious objections to such referrals.

planning. Consistent with the statutory requirement on nondirective pregnancy counseling, the Final Rule permits Title X projects to provide nondirective counseling on abortion.

HHS is committed to the women, men, and adolescents served by the Title X program and wants them to receive the best possible care available. Therefore, these priorities are designed to improve the breadth of services, especially for those unserved or underserved. That is why, in addition to their Title X funded family planning services, we encourage grantees and sub-recipients to ensure that comprehensive primary health care services are accessible, preferably in the same location or through nearby referral providers.

The third purpose of the Final Rule is to incorporate a stronger focus on **protecting women and children from being victimized** by child abuse, child molestation, sexual abuse, rape, incest, intimate-partner violence, and trafficking. The Final Rule requires that all Title X clinics provide annual training for staff to ensure compliance with state reporting laws, as well as on appropriate interventions, strategies and referrals to improve the client's current situation. The Rule also ensures consistency of care, and protection under the law, for women or children who have experienced any form of abuse.

The Department believes that Title X programs can best serve minors and other vulnerable populations by ensuring Title X providers have a plan for reporting abuse as required by State and local reporting laws. To ensure compliance with the annual appropriations rider mandating compliance with State notification or reporting laws[9], the Final Rule requires all Title X clinics to provide annual training for staff and to have a site-specific protocol in place to report crime and protect victims. As such, the rule helps ensure that Title X clinics are adequately identifying and addressing the laws and support needed for those who have been or are currently being abused. In addition, the Final Rule requires protocols to ensure that minors are provided with counseling on how to resist attempts to coerce them into engaging in sexual activity, to ensure compliance with another annual appropriations rider.

The Rule advises Title X projects and participating entities that they should comply with these reporting requirements and document the measures taken to comply, much as health care providers do in other contexts. The Rule ensures that confidentiality is not used as a reason for non-reporting of suspected abuse, without infringing in any way on client confidentiality, thereby protecting the most vulnerable.

The fourth purpose of the 2019 Final Rule is to **boost meaningful family communication, especially in adolescent family planning**. Title X programs are not permitted to require parental consent or notification before adolescents can obtain Title X services; however, Congress through statutory[10] and appropriation acts[11], made it clear that family participation in the family planning decisions, especially of minors, must be encouraged. The Final Rule requires clinics to meaningfully encourage parent/child communication while also recognizing

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[9] *See* Consolidated Appropriations Act, 2018, Public Law 115–141, Div. H, sec. 208, 132 Stat. 348, 737.
[10] PHS Act § 1001; 42 U.S.C. § 300(a)
[11] *See* Consolidated Appropriations Act 2018, Public Law 115–141, Div. H, sec. 207, 132 Stat. 348, 736.

that there are situations in which such encouragement would not be appropriate. The requirement would not apply if the Title X provider documents in their records that (1) the adolescent is suspected of being the victim of child abuse or incest, and (2) it has, consistent with applicable State or local law, reported the situation to the relevant authorities.

The fifth purpose is to **expand coverage, partnerships, and innovative approaches** through provisions designed to increase the number of clients served within the Title X programs. The 2019 Final Rule focuses on innovative approaches to expand Title X services and make inroads into sparsely populated areas that have historically lacked Title X services. By increasing innovation, expanding diversity of grantees, and clarifying the flexibility program directors have to provide services the rule increases the ability to reach more unserved and underserved areas.

The Final Rule is also intended to help **ensure reliability and certainty in the grant selection process**, while maintaining an open process similar to the selection process for other grants at HHS. Under Title X of the Public Health Service Act, 42 U.S.C. § 300 *et seq.*, the Secretary of HHS is authorized "to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects." 42 U.S.C. § 300(a). Once an applicant successfully demonstrates compliance with the Title X regulations, HHS considers each applicant fairly and competitively according to the scoring criteria set forth in the regulations.

The statute provides a set of non-exclusive factors that the Department may use in making grants. These include: "the number of clients to be served, the extent to which family-planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance." 42 U.S.C. § 300(b). The Final Rule should be comprehensive and rigorous, so that the strongest prospective grantees are more likely to be selected, and less qualified applicants would be less likely to garner high scores. The Department is focused on ensuring compliance with the statutory Title X requirements including the program integrity provisions in the appropriations riders; expanding the type and nature of the Title X providers and ensuring the diversity of such providers, so as to fill gaps in and expand family planning services offered through Title X; and using review criteria as a meaningful instrument to assess the quality of the applicant and the application. These goals are achieved under the Final Rule by more fully specifying the application criteria, while still adhering to the statutory requirement that certain factors be considered.

The agency makes grant decisions using a three-step process; this has been longstanding agency practice. First, the agency reviews application packages for compliance with application requirements, such as that they contain the necessary information and comply with procedural requirements, such as page limits. Generally, applications that do not meet these procedural requirements do not proceed to peer review.

Second, independent review panels, composed of outside experts, score the applications using the criteria set out in the Funding Announcement. Over the years, the scoring criteria have

largely tracked the seven factors required by the 2000 regulations.[12] The descriptions of the criteria in the Funding Announcements have regularly expanded on the regulatory language. For example, previous funding announcements have included focusing on priorities such as natural family planning, encouraging family participation and preventive health services. The panels do not determine whether an applicant will receive funding, but rather rate the applications to assist the Deputy Assistant Secretary for Population Affairs (DASPA) in making the final decision as to what grants to award. The scores represent non-binding recommendations to the DASPA.

Third, in the final step, the DASPA will make final award selections to be recommended to the Grants Management Officer for risk analysis. This is based on an independent determination, taking into account the review panel scores, as well as other broader considerations set out in the Funding Announcement, such as the geographic distribution of services within the identified service area and the extent to which projects best promote the purposes of the statute.

The sixth purpose of the 2019 Final Rule is to **return Title X flexibility to states and other grantees**. By formally revoking the 2016 regulation that limited the ability of states and other grantees to exercise flexibility in choosing their sub-recipients, the Final Rule restores the states' ability to prioritize funding according to the needs of the populations, and is consistent with Title X statutory and regulatory guidelines.

In 2016, the Department finalized a rule that amended Title X eligibility requirements, prohibiting any grantee/recipient making service sub-awards as part of its Title X project from excluding an entity from receiving a sub-award for reasons other than its ability to provide Title X services. Compliance with Title X Requirements by Project Recipients in Selecting Sub-recipients, 81 FR 91852, 91859– 91860 (Dec. 19, 2016) (adding paragraph (b) to 45 C.F.R. § 59.3) (the "2016 regulation"). The Department's stated reason for issuing the rule was to respond to new approaches to competing or distributing Title X funds that were being employed by several States. *Id.* at 91858–91859. The 2016 regulation took effect on January 18, 2017, but was nullified under the Congressional Review Act on April 13, 2017, when the President signed House Joint Resolution 43. *See* Public Law 115–23, 131 Stat. 89. Consistent with the joint resolution of disapproval, the Final Rule repeals the 2016 regulation and, thus, permits States and other Title X grantees freely to select Title X sub-recipients so long as they comply with the statutory, regulatory, and policy provisions in the funding announcement.

In summary, OPA, in the Office of the Assistant Secretary for Health, issued the Final Rule to revise the regulations that govern the Title X family planning program authorized by Title X of the Public Health Service Act to ensure compliance with, and enhance implementation of, the statutory requirement that none of the funds appropriated for Title X may be used in programs

[12] Agency regulations provide that the Secretary "may award grants" that "tak[e] into account: (1) The number of patients, and, in particular, the number of low-income patients to be served; (2) The extent to which family planning services are needed locally; (3) The relative need of the applicant; (4) The capacity of the applicant to make rapid and effective use of the federal assistance; (5) The adequacy of the applicant's facilities and staff; (6) The relative availability of non-federal resources within the community to be served and the degree to which those resources are committed to the project; and (7) The degree to which the project plan adequately provides for the requirements set forth in these regulations." 42 C.F.R. § 59.7(a).

where abortion is a method of family planning. OPA amended the Title X regulations to clarify grantee responsibilities under Title X, to remove the requirement for nondirective abortion counseling and referral, to prohibit referral for abortion, and to clarify compliance obligations with state and local laws. In addition, Title X regulations were amended to clarify access to family planning contraceptive services where an employer exercises a religious or moral objection. Finally, Title X regulations were amended to require physical and financial separation to ensure clarity regarding the purpose of Title X and compliance with the plain text of the statute, and to encourage family participation in family planning decisions, as required by Federal law. In its entirety the revisions to the rule, and the selection of grant recipients, will allow us to continue to place the well-being of women and families across the nation first and foremost.

Chair DeGette, Ranking Member Guthrie, and distinguished Members of the Subcommittee, this concludes my written testimony. Thank you for the opportunity to appear before you, and I would be pleased to respond to your questions.

Ms. DEGETTE. Thank you so much, Dr. Foley.

The Chair now recognizes herself for five minutes for questions.

On June 1, 2018, as we noted, HHS published a proposed rule to revise Title X and HHS received over 500,000 comments on the rule. I just wanted to ask you about a couple of those organizations that commented.

Many of the leading health organizations, over 19 of them representing 4.3 million providers, submitted comments that opposed the new proposed regulations. The American Medical Association, for example, said quote, "we are very concerned that the proposed changes, if implemented, would undermine patients' access to high-quality medical care and information, dangerously interfere with the physician-patient relationship, and conflict with physicians' ethical obligations, exclude qualified providers, and jeopardize public health," end quote

Were you aware of that AMA letter when you finalized the rule, Dr. Foley?

Dr. FOLEY. Yes.

Ms. DEGETTE. And in a comment letter, the American Academy of Pediatrics stated, "policy decisions about public health must be firmly rooted in science and increased access to safe, effective, and timely care. The proposed rule would interfere with the patient-provider relationship, exacerbate disparities for low-income and minority women, men, and adolescents, and harm patient health."

Were you aware of this letter by the American Academy of Pediatrics when you finalized the rule, Dr. Foley?

Dr. FOLEY. Yes.

Ms. DEGETTE. And in another letter, the American College of Obstetricians and Gynecologists stated, "the proposed rule regulates how providers talk to their patients and restricts the provider's ability to offer the patient his or her best medical judgment. The proposed rule uses medically inaccurate language, placing political ideology over science," end quote.

Were you aware of ACOG's letter when you finalized the rule, Dr. Foley?

Dr. FOLEY. Yes.

Ms. DEGETTE. And in its letter, the American Public Health Association stated, "the proposed rule would significantly and detrimentally alter the Title X Family Planning Program, which has provided vital sexual and reproductive health services to people across the country for more than 40 years."

Were you aware of APHA's letter when you finalized that rule, Doctor?

Dr. FOLEY. Yes.

Ms. DEGETTE. Now these are just four of the major medical associations that opposed the rule. Also opposing the rule were the American College of Physicians, the American Academy of Family Physicians, the American Academy of Nursing, and so on.

Now, I just wanted to ask you with seemingly every major national provider organization, the science organizations sounding the alarm, that rule was finalized with the most disconcerting provisions intact. Would you say you ignored the views and analyses of these leading health organizations? And if not, how did you take their views into consideration?

Dr. FOLEY. The Department would respectfully disagree with the premise of the question, in that the rule clearly allows for providers to have full and open conversation with their clients or patients, according to the statute. There is no——

Ms. DEGETTE. Well, let's talk about that statute for a second because, as noted by both my colleagues and by you, the statute says that abortion cannot be used as a form of birth control. Is that right?

Dr. FOLEY. As a method of family planning.

Ms. DEGETTE. Right. So I guess I wanted to ask you, are you aware of Title X money being used for abortions either for as a method of family planning or otherwise? Do you have evidence of that?

Dr. FOLEY. The Department, in writing the rule, had grave concerns about the possibility of——

Ms. DEGETTE. That's not my question, Doctor. My question is, Did the Department have evidence that Title X money was being used in violation of the statute to use abortion as a method of family planning?

Dr. FOLEY. There is evidence of significant confusion surrounding what Title X is being used for.

Ms. DEGETTE. That is not what the statute says, Doctor. That's not what the statute says.

In order to promulgate a rule, the Department is going to have to find that there is some violation of that statute. And what I am hearing from you is that there is no evidence that you are aware of that Title X money is being used to provide abortions as a method of birth control.

Dr. FOLEY. If you remember in 1988 the Department also promulgated a rule that was very similar to this rule. That rule was also reviewed by the Supreme Court and, at that time, the Supreme Court stated that that was an acceptable interpretation of Section 1008 of the——

Ms. DEGETTE. Well——

Dr. FOLEY. And so in that case, the Department has the ability to place in regulation rules that help to govern and make sure that there is statutory compliance in the Title X program.

Ms. DEGETTE. OK. So I would just point out that that regulation was more than 30 years ago and the legislation has been clarified that in its prohibition on Title X abortion funding, you can still have nondirective counseling of pregnant women.

The Chair now recognizes the ranking member for five minutes.

Mr. GUTHRIE. Thank you very much and I want to follow on what you just said with nondirective pregnancy counseling. One of the major provisions of the Protect Life Rule, which was proposed in June 2018 and finalized in March 2019 is that it permits but no longer requires nondirective pregnancy counseling, including nondirective counseling on abortion to be provided by physicians, practitioners, and nurses with advanced degrees.

So Dr. Foley, what is nondirective pregnancy counseling, and why was such counseling previously required, and why has HHS revised it now so that nondirective counseling is permitted but not required?

Dr. FOLEY. The 2000 regulation discusses the fact that it does not require pregnancy counseling. It says if there is pregnancy counseling, that it must be nondirective. And nondirective is defined in the fact that information is given but the provider does not direct the client one way or the other, it does not support in one way or an other in their counseling. So it is nondirective counseling.

The Department felt very strongly that it was not appropriate for there to be regulations that specifically required or specifically prohibited any conversation of healthcare providers with their clients; that that needed to be up to the discretion of the clients and the provider. And that is why in the final rule that it is permitted but it is not required.

Mr. GUTHRIE. So, all these organizations that letters were just quoted from can still have these conversations with Title X funds——

Dr. FOLEY. Absolutely.

Mr. GUTHRIE [continuing]. But they are just not mandated to do so.

Dr. FOLEY. Exactly.

Mr. GUTHRIE. So, we are not interfering with a doctor-client relationship that the previous law/rule actually does that, the law that——

Dr. FOLEY. The regulation that we are currently under because of the enjoined new rule states that if the patient requests it, the provider is required to provide that information to them.

Mr. GUTHRIE. So, it has to be requested.

Dr. FOLEY. Again, that is requiring a physician to talk about something and that is, to me, very similar to prohibiting them from talking about something, which is why the Department felt like that it needed to be very clear.

Mr. GUTHRIE. Let me get to another. In your testimony, you state the Title X statute says, "we have said this a couple of times, none of the funds appropriated under this Title shall be used in programs where abortions are a method of family planning. This is different from the traditional Hyde Amendment that says none of the funds may be used for abortion or health benefits that include abortion."

Can you explain why the reference to quote, a program where abortion is a method of family planning is so important?

Dr. FOLEY. There is a difference between paying for the procedure itself and also in any way encouraging or supporting that. And that is why in Section 1008, where it said these funds may not be used in a program where abortion is considered a method of family planning, the Secretary's opinion, the Department's opinion, is that if as a part of that you are referring a client for a service of family planning, you indeed, are violating Section 1008.

Mr. GUTHRIE. Thanks. I want to get another question.

There has been some concern that the new rule about the access to contraception, which is different from the issue we just discussed. As you noted, in the Title X Family Planning must offer a broad range of acceptable effective family planning methods and services. The broad range doesn't need to include all categories but, according to fiscal year 2019 funding announcement, should include

hormonal methods of contraception, which is probably the most commonly requested I understand.

So why does the funding announcement say Title X grantees should include hormonal methods of contraception?

Dr. FOLEY. Because that is an important part of providing a broad range of effective and acceptable family planning methods and services. It is interesting to note that the 2000 regulation does not mention contraception as a requirement. It simply states the acceptable and effective.

This regulation, the new regulation specifically includes contraception in the requirements for what a grantee must provide within their project.

Mr. GUTHRIE. So that must be provided in that project.

So how does the—so we are going back to the previous issue on funding of family planning in relation to abortion, how does that provision of the rule interact with the Weldon Amendment, which prevents HHS funding recipients from discriminating against healthcare providers because they refuse to provide, pay for, or refer to abortion?

Dr. FOLEY. There is support there and that is because there are Federal statutes that support the ability for someone to not refer for abortion or counsel about abortion as a result of a conscience for them.

Mr. GUTHRIE. Thank you.

My time has expired, and I yield back.

Ms. DEGETTE. I thank the gentleman.

The Chair now recognizes the gentle lady from Illinois, Ms. Schakowsky, for five minutes.

Ms. SCHAKOWSKY. So in 1967, an eager supporter of federally-funded family planning wrote to Congress and said, "no American woman should be denied access to family planning assistance because of her economic condition," and that supporter was President Richard Nixon. And the next year, the Title X Family Planning Program was finally enacted into law with broad support. Co-sponsors of the legislation that established the program included several Republican members, including then-Congressman George H. W. Bush. And at the time, there was an understanding on both sides of the aisle that many Americans, and especially low-income women, were having more unintended pregnancies than they wanted.

And both Democrats and Republicans understood that the primary driver of this phenomenon was inequitable access to contraception and reproductive health services.

Researchers suggest that unintended child-bearing increases poverty, limits education, reduces women's ability to participate in the workforce, and was an overall detriment to the health of women and girls. And so, the United States listened to the experts, considered the facts, followed the science, and established Title X. And almost 50 years later, what we are looking at is the Trump administration deciding to turn back the clock and really, in many ways, decimate for many people the robust network of family planning providers across every State-so far, still Missouri has availability of full range of reproductive health-in our nation.

So here is, I think this is all about abortion. The name of the bill, the rule that was passed,—what is it—Protect Life, something like that. This is about abortion. This is about trying to limit women from having their full reproductive rights. Because what doctors, then, have the option of is either withholding critical information and limiting care to their patients, leaving the program and scaling back clinic services, laying off staff, or closing their doors due to the limited resources. And all of these options are completely unacceptable.

The chairwoman of the subcommittee listed all of the groups, literally all of the health provider groups, that oppose this rule and have written very carefully what they said. Nineteen leading women's healthcare provider groups, medical organizations, and physician leaders have stated, and here is a quote, "this regulation will do indelible harm to the health of Americans and to relations between patients and their physicians by forcing providers to omit critical information about health, healthcare, and resources available. The final regulation directly undermines patient confidence in their care. There is no room for politics in the exam room." This is the politics of abortion that we are dealing with right now.

And I want to just state for the record women are not going back. Women are not going back. This is not going to be tolerated right now. And what I don't understand—are you saying that any clinic now that provides comprehensive healthcare, comprehensive scientific healthcare, can no longer co-locate with any clinic that itself separately provides abortion?

Dr. FOLEY. Yes, that is what the new rule states.

Ms. SCHAKOWSKY. So the many, I don't know what the number is, but the many clinics that do provide the whole range of healthcare, those clinics, some that are the only provider in a community, will have to somehow change their way of functioning entirely. Do you not think that is going to be a difficult process?

Dr. FOLEY. Again, it is not whether or not it is going to be difficult, that is not the issue that this regulation is addressing. It is addressing the fact that the statute says that these funds may not be used in a program where abortion is a method of family planning. And that, again, has been part of the statute since it was developed.

Ms. SCHAKOWSKY. This is not going to stand and women around this nation are not going to tolerate that.

Thank you. I yield back.

Ms. DEGETTE. I would just point out that is not what the statute says. We can get to that later.

I would now recognize the ranking member of the full committee, Mr. Walden, for five minutes.

Mr. WALDEN. Thank you, Madam Chair.

Again, Dr. Foley, thank you for being here.

What can physicians operating in a Title X clinic do under the 2000 regulations that they can no longer do under the Protect Life Rule? I think that is the heart of the matter here.

Dr. FOLEY. There is nothing that physicians, healthcare providers, nothing that they cannot do except refer for abortion.

Mr. WALDEN. For family planning purposes or for any purposes?

Dr. FOLEY. For family planning purposes—no, for family planning purposes. They are permitted to refer for abortion in the case of a medical situation or in the case of rape or incest.

Mr. WALDEN. OK.

Dr. FOLEY. However, for family planning services, the prohibition against referral for abortion as a method of family planning.

Mr. WALDEN. And is it your position that the underlying statute already precludes that?

Dr. FOLEY. Yes.

Mr. WALDEN. So why did HHS make these changes? What you were asked earlier, you didn't really have a chance to respond in depth. Was there any evidence of misuse of program dollars?

Dr. FOLEY. The Secretary felt that there was significant opportunity for commingling of funds when there was co-location of family planning provided services in a single location where abortion was provided. There was opportunity for commingling of funds.

He also went on to state that if, by being co-located, a Title X provider was able to benefit from economy of scale, fungibility of funds in any way, that also would be in violation with Section 1008, which required that these funds may not be used in a program where abortion is a method of family planning.

And based on his opinion, based on the opinion of the Supreme Court finding that, again, this was a reasonable interpretation, they also found those regulations to be completely clear from any violation, statutory or constitutional as a result of that.

Mr. WALDEN. OK. Some Community Health Centers are concerned the changes to Title X will interfere with the patient-provider relationship by limiting the provider's ability to give their patients comprehensive information, even when the patient directly asks for that specific information.

So, my question is, once the Protect Life Rule is fully implemented, is there any information that a physician operating in a Title X clinic will no longer be able to share with his or her patient?

Dr. FOLEY. There is not.

Mr. WALDEN. None?

Dr. FOLEY. No, they are completely free, in a nondirective way, which is mandated by Congress, that any counseling must be nondirective. However, they are not prohibited from having full conversations, answering those questions that their clients have.

Mr. WALDEN. So if a client came in and they had a child that they were expecting determined to have a medical problem that could be fatal, could that doctor say here are your options: you could terminate the pregnancy today; you could do compassionate care; or you might do some extraordinary activity after birth?

Dr. FOLEY. Yes, they are free to provide counseling on all of the options, including the options of abortion for their client.

Mr. WALDEN. OK. Now as I mentioned earlier, my district is—well, it's bigger than any State east of the Mississippi, so getting access to care for Oregonians is really essential in these very rural, underserved areas. They have three counties with no doctors and hospitals, hundreds of miles in-between.

So, talk to me, given your experience as a pediatrician, as somebody who has served in these sorts of areas, are a change to the

rules going to adversely affect my constituents' ability to access reproductive health services and healthcare in these Community Health Centers?

Dr. FOLEY. One of the other changes in this regulation and rule is to encourage grantees to apply who have shown innovative ways to address services for those particularly in unserved or underserved areas, particularly rural areas. And we are hopeful that there will be grantees that will provide those services that currently are not being provided in some areas.

Mr. WALDEN. Because I understand under perhaps the existing contract grant application process, one of the criteria is to look at total number of people served. And as I said, I have got counties with less than 2,000 people and hundreds, and hundreds, and hundreds of square miles. And it seems to me, under the current rules, they could be excluded.

Dr. FOLEY. Again, those criteria are not exclusionary. It is one of the factors that we look at to determine who provides the best coverage for a broad range. Those are not exclusionary.

However, I agree with you that if there is increased rural coverage, there may be a decrease in the total number of patients serviced. However, the opinion of the Department is that——

Mr. WALDEN. Un-accessed.

Dr. FOLEY [continuing]. In urban areas, there are other access areas for them.

Mr. WALDEN. Thank you. My time has expired.

Thank you, Madam Chair.

Ms. DEGETTE. Thank you so much.

The Chair now recognizes Dr. Ruiz for five minutes.

Mr. RUIZ. Thank you, Chairwoman.

Dr. Foley, my name is Dr. Raul Ruiz and doctor to doctor, I want to tell you I am very concerned about the proposed changes to the Title X Family Planning Program.

I represent the constituents of California's 36th District to rely on the services of seven health centers that are Title X-funded and most of them function in underserved, hard to reach communities.

The Title X program has been in place for 50 years and helps around four million people very year by providing them with essential services like birth control, HIV/STD testing, men's healthcare, and pregnancy testing. And Dr. Foley, as you mentioned, you are a former Title X provider. You and I know that the program helps low-income, uninsured individuals, and individuals who live in rural areas.

The administration's recently published final rule on Title X will harm the four million people it is intended to help. One of the provisions in the final rule prohibits Title X providers from referring their patients for abortion services, even if specifically requested.

Now you just heard an example about an extreme case, where somebody's health is on the line but how about the 13/14-year-old made, a mistake, comes into the clinic, says "I want to know my different options." Mother is there with her and says, "What are my options? Can you refer me to an abortion clinic?" Just for family planning, saying "it is not my time, I am not prepared, I am in a dysfunctional situation." Can that doctor refer that patient to an abortion service clinic?

Dr. FOLEY. According to the statute, abortion cannot be used—the funds cannot be used in that.

Mr. RUIZ. So no.

And the other thing that this bill does is that it leaves doctors to decide whether or not to follow certain guidelines, whether or not to even refer them, even if they ask as well. And that is a problem, you see.

We all know that Title X funds do not go towards abortion. It never has. And you cannot even give us one example of any violation of that statute or one example of Title X money going towards abortion. You can't even give us an example. That fear is unfounded.

Last year, the New England Journal of Medicine published a perspective that stated that this rule, in fact, changes implemented in April 2017 already allow grantees to shift Title X funds away from sites that also provide abortion. It already does. Several statute and appropriation restrictions already protect providers who refuse on the basis of conscience to refer clients for abortion service. They already have that option.

These proposed regulations go farther by restricting providers' ability to deliver sound patient care in, essentially, dismantling the well-established, well-functioning Title X care system, disregarding local community care systems and policy preferences. The consequence changes in the Title X system are likely to increase unintended pregnancy rates in the most vulnerable segments of the population and are, thus, more likely to increase than to reduce the incidence of abortions.

I represent a district with rural and underserved areas and this rule would create barriers that disproportionately impact low and rural communities and augment the unsafe use of abortions.

Given your training and background as a pediatrician, do you agree that the patient-provider relationship must be built on trust?

Dr. FOLEY. Yes.

Mr. RUIZ. Numerous medical associations have strongly opposes the rule for this very reason, including the American Medical Association, the American Academy of Pediatrics, the American College of OB/GYN, and the American Nurses Association. In fact, the AMA, says "the ability of physicians to have open, frank, and confidential communications with their patients has always been a fundamental tenet of high-quality medical care. The proposed rule would violate these core principles by restricting the counseling and referrals that can be provided to patients and by directing clinicians to withhold information critical to patient decisionmaking."

The exact same example that I told you of a young adolescent, maybe 18-year-old, 17-year-old coming in saying I want to know all my options. If that doctor cannot give that patient the full spectrum and help that patient understand the full risks and benefits of that clinical case of all the different options available to that woman or girl, then they are violating their patient trust relationship. And that's why many organizations and many doctors, including myself, are opposed to this rule.

I yield back my time.

Ms. DEGETTE. The gentleman yields back.

The Chair now recognizes Dr. Burgess for five minutes.

Mr. BURGESS. Dr. Foley, let me just give you a chance to respond to what you just heard.

Dr. FOLEY. There is nothing in the rule that prohibits a healthcare provider from giving the full range of information about all the options, including everything you just said. There is nothing that prohibits them from giving all of that information to their clients.

Mr. RUIZ. You told me——

Mr. BURGESS. Actually, reclaiming my time, Doctor, now, it was also asserted that the rule creates barriers to care. Can you address that?

Dr. FOLEY. The new rule?

Mr. BURGESS. The new rule.

Dr. FOLEY. The barriers to care that it may create, there are many providers that avoid being a part of the Title X program because of the current regulation that states that they are required to refer for abortion and that they are required to have counseling about that. And so there are a number of providers that don't participate, as a result of that.

Mr. BURGESS. Very well. And I know Mr. Guthrie asked you some questions on the nondirective counseling part. And just to follow-up on that a bit, you did say that it was up to the discretion of the client and the provider. Can you clarify that?

Dr. FOLEY. The counseling is client-directed, based on the questions they are asking and what they have. The nondirective counseling is there is instruction that you provide the options, a full discussion of the options that they have and explain that to them. There is no prohibition on having that conversation.

Mr. BURGESS. Now we also heard that the nondirective counseling was equivalent to a gag rule. Can you address that?

Dr. FOLEY. If you were prohibited from counseling about a certain area or prohibited from having that conversation, that would be a gag rule. The fact of the matter is, this new rule gives providers, does not prohibit them, in fact it allows them to have that conversation, whatever conversation they would like to have with their clients.

Mr. RUIZ. Would the gentleman yield?

Mr. BURGESS. No. The other issue, of course, is co-location and how is this rule addressing the co-location, commingling aspect?

Dr. FOLEY. There is great concern that co-location increases the opportunity for commingling of funds for fungibility for use of the funds for infrastructure and other things. That was a significant concern; enough of a concern for the regulation to be changed. What is interesting is that that concern was upheld by the number of comments we receiving showing significant misunderstanding of what the rule actually states; and talking about the need for abortion to be a part of what is covered, and significant confusion not only from commenters but as well as the general public.

So in order to have statutory compliance with integrity, the final rule was engaged in the way that it was.

Mr. BURGESS. So let me ask you this. State flexibility and competition don't seem like they have always been given a high priority within the Title X program. How does the new rule aim to increase diversity amongst grant applicants?

Dr. FOLEY. Part of the priorities are to look for innovative ways to, again, address areas that are underserved or unserved as a result of the Title X program and funding. So with those changes, that is encouraged and grantees are encouraged to provide those types of services, as they apply for this.

Again, this is a competitive grant process. And so part of that competition is looking to see what provides the best coverage and into the areas of priority.

Mr. BURGESS. So you noted that the 2019 final rule requires medically-necessary referrals, such as referrals for prenatal care, for the health of the mother, as well as the baby. Was medically-necessary care for prenatal care not required under the previous rule?

Dr. FOLEY. That is right, it was not required.

Mr. BURGESS. So what prompted you to add this portion to this rule?

Dr. FOLEY. The idea of medical necessity was very important, particularly with the changing climate that we have seen with increased maternal mortality. And we know that the earlier someone who is pregnant is referred for prenatal care, the more likely they are to have a better outcome, both for them and for the child. And so in that case, that was the reason that this was considered a medical necessity that they would be referred.

Mr. BURGESS. And you may mark me down as being supportive of that change.

So I will be happy to yield the last 16 seconds to Dr. Ruiz. Now, he's absent. Absent without leave.

So Dr. Foley, just thank you for being here and testifying today. It has, I think, added a positive measure to the discussion.

And I will yield back.

Ms. DEGETTE. The gentleman yields back.

The Chair would just note that the rule says that medical professionals can have a full conversation, including about abortion but only—even if the patients asks, but only in the situation of medical necessity, rape, or incest. So at other times, they would be prohibited from having those conversations.

The Chair will now recognize the chair of the full committee for five minutes.

Mr. PALLONE. Thank you, Madam Chair.

I am obviously opposed to this rule but the thing that strikes me is how it is totally unnecessary. Just as an example, the proposed rule sets about requiring onerous physical and financial separation between Title X programs and those from abortion services, including referral, counseling, and any activity related to abortion. And the justification given by HHS is that it will, and I quote, "protect against the intentional or unintentional commingling of resources." Yet, I don't see any evidence that this is actually happening, that there actually is commingling of resources.

So I wanted to ask Dr. Foley, isn't it true that the Office of Population Affairs already had robust grantee reporting program reviews and auditing process in place before the proposed rule? Yes or no. You can just say yes or no if you want.

Dr. FOLEY. There are provisions for that in place, however, that is not spelled out in the current regulation.

Mr. PALLONE. Now you said, I guess in response to Dr. Ruiz, that there has been confusion whether Title X funds have been inappropriately used to perform abortions. I think that is what you said. If you disagree, you can say.

But are there formal OIG audits? And if so, can you point to any in this regard that lead with regard to your statement about the confusion?

Dr. FOLEY. The purpose of this was, again, to make sure that there was integrity and that the original intent was followed.

Mr.PALLONE. But I mean were there any OIG audits?

Dr. FOLEY. Not that I am aware of.

Mr. PALLONE. All right. In his order granting a preliminary injunction on the implementation of the Title X rule, Judge McShane, who I quoted earlier, said, "despite the nearly 50-year history of Title X, HHS cannot point to one instance where Title X funds have been misapplied under past or current rules."

And I guess perhaps this explains why the American Medical Association said in their comments on the rule, and I quote, that "HHS fails to justify why physical separation is needed." So Dr. Foley, can you understand why the AMA and other medical and public health organizations point to a lack of justification for the new rule when HHS itself can't provide evidence that the additional physical separation requirements are necessary?

Dr. FOLEY. Again, the program integrity is the purpose of this rule. It was—that was the motivation for writing that, to make sure that according to statute that these funds are not used in a program where a program is a method of family planning.

Mr.PALLONE. Well I understand what you are saying but I mean the problem is you know you go in to do these proposed rules, you are trying to say, accomplishing something which we don't even know whether or not there is a problem, and you yourself are saying there is some confusion about whether there really is a problem.

So I mean it is all very nice to say you are trying to accomplish something but you create all this mischief at the same time. I don't mean you but, you know the Department.

I mean because HHS' Title X rule has been enjoined by the judge, the longstanding requirements for Title X remain in place and this includes a requirement that all pregnancy counseling must be nondirective, including information on all available options: including adoption, prenatal care, abortion. Yet, last week HHS has stated that it will not enforce this requirement with regard to abortion referrals.

So Dr. Foley, does HHS intend, in your opinion or if you know, does HHS intend to enforce other requirements for Title X projects, namely, that they must provide the full range of medically-approved contraceptives, including hormonal and long-acting options, do you know?

Dr. FOLEY. What they were referring to in that specific situation was the protection that is provided under a number of Federal laws for conscious protection.

Mr. PALLONE. Well, I understand that, but what I am——

Dr. FOLEY. And what they were not going to be able to enforce——

TMr.PALLONE [continuing]. Concerned about though is that if HHS doesn't enforce these other requirements, that they have to provide the full range of contraceptives, hormonal, long-acting options; I am just afraid that you know they are just going to give out Title X funds to some group that you know just wants to narrowly focus their medical advice or whatever, or their advice on just a few things and not the full range of options in terms of family planning. And that is not what we intend with Title X.

Dr. FOLEY. The Title X will continue to, as it has, require that grantees provide a broad range of effective and acceptable family planning methods and services. That will continue to be required.

Mr. PALLONE. Well, I hope so because I am very concerned that what we may get into is very narrowly focused clinics or healthcare services that don't allow these, and then that becomes the full range, and then that becomes ideological in itself, which this administration is known for.

In any case, I think that I certainly agree with healthcare leaders that say that the administration should retract its regulation because family planning policies shouldn't be—should be driven by facts, evidence, and necessity, not politics and ideology. And I think this is headed towards an ideological program, which is the last thing we need.

But thank you for being here. I appreciate it.

Ms. DEGETTE. The gentleman yields back.

The Chair now recognizes the gentle lady from Indiana, Mrs. Brooks, who, by the way, we are all very saddened about your news that you are leaving us.

Mrs. BROOKS. Thank you. Eighteen months to go, important work to do, and I will certainly miss this committee and the fine work that we are doing together.

I do want to ask you, Dr. Foley, you lead the office that oversees these grants. Is that correct?

Dr. FOLEY. That is correct.

Mrs. BROOKS. And in your written testimony, in addition to, because there is much being talked about with respect to the nondirective counseling, in your written testimony you have indicated that this final rule places a high priority on preserving the provider-client relationship and the regulation permits but does not require nondirective pregnancy counseling, including nondirective counseling on abortion. Is that correct?

Dr. FOLEY. That is correct.

Mrs. BROOKS. And that is what you have said today. So this means—and I would also like to point out that the Federal Register, which has tried to explain a lot of this, and it is like 103 pages long, but it talks about nondirective counseling does not mean that the counselor is uninvolved in the process or that counseling and education offer no guidance but, instead, that the clients take the active role in processing their experiences and identifying the direction of the interaction. And they may provide, still, what I am reading. A Title X provider may provide a list of licensed, qualified, comprehensive primary healthcare providers, some of which may provide abortion. Is that correct?

Dr. FOLEY. That is what the rule states.

Mrs. BROOKS. That is what the rule states. And so while yes, there is much discussion about this, it does not mean that nondirective counseling—what does nondirective counseling mean to you, as a doctor?

Dr. FOLEY. Nondirective counseling means that the information is provided, the questions are answered, but I do not direct them one way or another towards a decision.

Mrs. BROOKS. It seems very clear but yet still, as a provider, you must and may lay out all of the options.

Dr. FOLEY. That is correct.

Mrs. BROOKS. That is correct but you may not tell the patient what is best for them, or what is appropriate, or what you like, or don't like? What does that mean? Let's talk about that a little bit.

Dr. FOLEY. When you look at the statute, what it says is, again, these funds cannot be used in a program where abortion is a method of family planning. So any encouragement of, promotion of, support of, referral for abortion would violate that standard.

Mrs. BROOKS. And that is Section 1008——

Dr. FOLEY. That is right.

Mrs. BROOKS [continuing]. Of the law that is in place.

Dr. FOLEY. That is correct.

Mrs. BROOKS. I want to shift a moment to make sure that people understand that in the 2000 Title X rule, it did not mention contraception but the new rule does explicitly list contraception. Because I want to make sure people realize this rule is not trying to take away contraception.

Why did you add a direct mention of contraception in the rule?

Dr. FOLEY. By definition, when the statute requires that these grantees provide a broad range of effective and acceptable family planning methods and services, contraception is a very critical part of that and that needs to be included. And it was to clarify the fact that the intent of the Department was not to remove contraception as an option for the women, and men, adolescents that are seeking that.

Mrs. BROOKS. Can an entity that provides only one method of family planning service receive funding as a Title X grantee?

Dr. FOLEY. This was actually part of the 2000 regulation as well, where it states that each sub-recipient is not required to provide all of the methods; however, within a project, all of those must be provided.

So this has been something that has been in place since the 2000 regulation was in place and this has just been continued into the new regulation.

Mrs. BROOKS. And how do you and your Department that is overseeing this entire project and the grantees, how do you determine whether or not they have provided a broad range of family planning methods?

Dr. FOLEY. They are required to list the sub-recipients and what services they are going to be offering. And we look at those, look at the geographic area that they have indicated that they will cover, and make sure that a broad range is available in that area, as much as is possible.

Mrs. BROOKS. Thank you. I yield back.

Ms. DEGETTE. The Chair now recognizes the gentleman from Maryland, Mr. Sarbanes, for five minutes.

Mr. SARBANES. Thank you, Madam Chair.

Thank you, Dr. Foley, for being here, as we discuss the implementation of the Title X gag rule, which seems to have occurred not just without any real scientific or medical input, in my view, but in spite of those things.

I want to echo what has been pointed out by my colleagues, many patients seeking care at Title X clinics have no other source of care. This is really critical. In fact, there is a 2016 nationally-representative study that showed that 60, six-zero, percent of Title X patients had no other source of healthcare in the prior year.

I am very proud that in Maryland, we have been a leader in expressing our opposition and taking action against the gag rule and the negative impacts that it would have on Maryland communities. As a State, Maryland receives about $3.2 million in annual funding from Title X. Almost half of that, $1.43 million, goes to the City of Baltimore, which I represent, which uses it to provide a range of services to more than 16,000 patients annually.

In the Federal lawsuit that was filed against HHS to prevent the rule from taking effect, Baltimore City outlines that many Title X grantees would lose funding under this rule and the city would be then responsible for replacing that lost funding. If not replaced, the public health impacts would include an increase in unintended pregnancies, an increase in sexually transmitted infections, an increase in undetected cancers, and a decrease in access to prenatal care. Each of these issues is associated with increased healthcare costs for patients and for the city.

Now you know that Title X was enacted by Congress in 1970, correct? And that represented a commitment at the Federal level to provide funding for family planning services and to make that, in part, a Federal responsibility.

What I am curious about is when this rule was being developed, were considerations given to how the grantees would inevitably lose Federal funding; many of the ones who are currently receiving Title X, and how this would impact the communities that they are located in? In other words, did anyone in your office consider how State and local funding would have to be diverted from other sources to support the family planning activities that would no longer be receiving Federal support? Was that part of the analysis?

Dr. FOLEY. There is nothing about the new rule that intends to keep providers from being part of the Title X program. The purpose of the rule was to make sure that there was statutory compliance with the regulations, the mandates that are in place in the statute.

And the decision for grantees—again, this is a competitive grant process, the decision for grantees is their decision to make. There was nothing in this rule that would preclude anyone from being a part of our Title X program, as long as they complied with the regulations, and the statute, and the mandates, bringing things back into compliance with the intent of Congress in establishing this rule.

Mr. SARBANES. I understand but you are sort of putting blinders on. I mean you can stick to that narrative and I understand why you are doing it but, in terms of continuing to meet the Federal

Government's responsibility and intention of making sure that these kinds of services are available, particularly in low-income communities, others who have difficulty accessing this kind of care, instances where it is the only source of care, it seems to me that your office ought to have given consideration to what the practical impact would be, what the ripple effect would be. That's the kind of perspective that when you are developing a new regulation ought to be in the mix. There is no evidence that that happened here.

And the impact that is being predicted from implementing this gag rule is it will have a tremendous effect on access to care and all of the services that I referred to a moment ago. So, I would recommend that you broaden the lens here and look seriously at how the effects of this rule cut against what Congress intended when it put the program in place back in 1970; and I think that that commitment represents the expectations of the broad majority of Americans across the country.

With that, I will yield back my time. Thank you.

Ms. DEGETTE. The Chair now recognizes the gentleman from Oklahoma, Mr. Mullin, for five minutes.

Mr. MULLIN. Thank you, Madam Chair.

Just there is a lot of confusion about what the rule does and doesn't do. And first of all, it seems like people are thinking that it makes a change to the law itself, especially when it is pertaining to abortions. But underneath Section 108 it says, very specifically, it says none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning. Is that correct?

Dr. FOLEY. Yes.

Mr. MULLIN. Does your rule make any changes to that?

Dr. FOLEY. No, it did not.

Mr. MULLIN. So this is current law that has been there since 1970. Is that what we just referred to?

So there is no changes to that. So some of my colleagues on the other side of the aisle now want to add to it and say that that should be an option now offered but, underneath current law, that can't be an option. Is that correct?

Dr. FOLEY. Yes, that is correct.

Mr. MULLIN. And let's just say because Planned Parenthood seems to be brought up here a lot, there isn't any services that Planned Parenthood currently offers underneath the clinics that are operating underneath Title X that changes, right? They just can't perform abortions but they have never been able to perform abortions out of the same building. Is that correct?

Dr. FOLEY. The co-location—currently, there is co-location of a number of clinics that provides abortions as well as providing Title X services. The change in what Title X funds can pay for has not changed.

Mr. MULLIN. Right, so that doesn't change. You are just saying that they can't perform them out of the same building.

Dr. FOLEY. The idea that there is the opportunity to commingle funds, there is the perception, certainly, by the public, by grantees, by other people that Title X covers that because it is in the same location, these——

Mr. MULLIN. As a business, sure.

Dr. FOLEY [continuing]. Are all of the things that we were concerned.

Mr. MULLIN. Absolutely. Well, as a business owner, the way I can cut costs from business, to business, to business, because my wife and I own multiple businesses, is that we can utilize the resources by bringing them underneath one building. We can utilize the electric. We can utilize the cost of overhead. We can utilize personnel and they can coexist underneath one umbrella and it brings down the cost. It is cost-sharing among the companies. And what we are saying is that because it is 100 percent prohibited underneath Title X from 1970, we just got to make sure that isn't happening. And underneath the new rule, you are trying to clarifying that, correct?

Dr. FOLEY. That is correct.

Mr. MULLIN. Because it has been kind of a gray area because we have some on the left that think that tax dollars should be used for abortions but, yet, the law doesn't say that. The law is very, very clear.

So those on the other side of the aisle, if they wanted to try to change that, then they need to change the law but your rule doesn't make a change to this. So the gag order, to whatever they are saying, they are calling it, that's actually just a myth. Is that correct?

Dr. FOLEY. The gag rule—it is not a gag rule.

Mr. MULLIN. Which they refer to as a gag rule.

Dr. FOLEY. It is not a gag rule.

Mr. MULLIN. Right, it is just clarification.

Does the new rule help with rural areas, as far as trying to get services to family planning?

Dr. FOLEY. It is a priority of the Department and it is made specifically in the new regulation that part of the grant application process will place a priority on serving underserved or unserved areas and many of those are rural areas.

Mr. MULLIN. Because a lot of times rural areas are you know overlooked because they are rural but it still is very important. My district is extremely rural and we do need resources down there. We need to make sure that we are not overlooking it, that disproportionately, the dollars are going to major metropolitan areas. It needs to be proportionately spread out to the rural. So I do appreciate that.

How does it encourage parent and child communication in family planning decisions?

Dr. FOLEY. The mandates from Congress, for a number of years, have stated that there needs to be family involvement when it comes to, particularly, adolescents in their decisionmaking. And while that has been in the mandate, there has been nothing in current regulations that actually operationalize that or explain how that should be done and how that needs to be reported back to the Federal Government if Title X funds are going to be used in that situation.

Mr. MULLIN. And adolescent is age—what do you consider an adolescent?

Dr. FOLEY. Adolescent, that varies depending on who you are talking to but, typically, it is a minor, someone who is considered a minor.

Mr. MULLIN. Under 18.

Dr. FOLEY. And that may change. That may change depending on the State laws and that type of thing.

Mr. MULLIN. Just like we have tobacco laws, just like we have drinking laws, age appropriate. This is still the same thing and this doesn't change it. It just clarifies it that it needs to—we need to do more to encourage family participation when an adolescent is facing a very, very tough decision.

Dr. FOLEY. Right. And again, it also does clarify that there are situations if the adolescent is in danger that that is not required.

Mr. MULLIN. Right.

Dr. FOLEY. For example, if we know that there is abuse going on or if it has already been reported to the State and local authorities, then the encouragement to include family is not a part of what will be done through this regulation.

Mr. MULLIN. Thank you.

Madam Chair, I yield back. Thank you.

Ms. DEGETTE. The Chair now recognizes the gentle lady from New York for five minutes.

Ms. CLARKE. Thank you, Madam Chairwoman, and I thank the ranking member for convening this very important hearing on what can be done or should be done to safeguard quality family planning care.

I am deeply concerned that, at a time when we should be discussing how to dramatically increase Title X funding and bring reproductive healthcare to millions of women in need, we are instead being forced to focus our oversight authority on how to protect Title X from the Trump administration's recent assault on women's reproductive rights and women's health and well-being.

Despite the important mission of Title X, Federal funding has decreased by $31 million nationally since fiscal year 2010. Over $1 million of this decrease in funding has occurred in my home State of New York. Even with this decrease, Title X has remained a critical source of funding throughout New York City. Between years 2012 and 2015, 22 different organizations in New York City received Title X funding, enabling these organizations to provide comprehensive primary and reproductive healthcare services to an average of 148,000 New Yorkers annually.

Three of these clinics that rely on Title X funding are situated right in my congressional district within Brooklyn, where I was born, raised, and live to this day. All three health centers provide essential sexual and reproductive healthcare to low-income women, women of color, and other underserved patients every day. They also provide patients with a range of preventative care services that might otherwise be out of reach, including breast and cervical cancer detection.

Now, through its proposed gag rule, the Trump administration is directly undercutting Title X by forcing health centers to make the impossible choice between proper healthcare on the one hand and Federal funding on the other. The Trump administration's recent proposal is nothing more than an effort to undermine women in our

human right to preventative healthcare. We must, therefore, safeguard Title X to ensure that all patients, regardless of their background, social status, or whether they have health insurance, has access to quality healthcare.

What I find interesting is the wordsmithing that has been taking place here today. None of what you are trying to preempt has even occurred. You have yet to state anything that says that you have evidence that people are commingling dollars, that any of this is taking place. And so we are only left to what we see and know has been an ongoing assault on women's reproductive rights.

So Title X serves a disproportionately high number of black and Latinx patients, compared to national rates. In fact, nearly one-third of the Title X patients are people of color. Public health professionals and leaders within communities of color have raised serious concerns regarding the potential impact of Trump administration's new Title X rule.

Dr. Foley, why has HHS disagreed with the American Public Health Association's assessment of the impact of the new rule as it relates to health inequities within the United States? What the American Public Health Association says is that "increased health inequities widen the gap between women who are able to access healthcare services and those who are not."

Dr. FOLEY. There, again, is nothing in the new regulation that precludes any of our current Title X grantees from receiving funding as we move forward. Again, when we are talking about the ability for a healthcare provider to provide a full range of information to their clients, there is no restriction on that.

Earlier——

Ms. CLARKE. I understand what you are saying but here is the thing. Most organizations are able to segregate their funding streams. And you are making it seem as though there has been this mass issue of commingling of funds. This has never been the case. You failed to document it. And it would seem to me that you would be proceeding based on fact. What you are doing is proceeding based on speculation.

So my next question, Dr. Foley, is: According to black women leaders of Our Own Voice, a partnership of five black women-led organizations serving communities across the country, Title X, the gag rule, would be especially detrimental to low-income women and women of color. We already face heighten barriers to family planning resources. HHS is gambling with our lives, putting black women at an even greater risk.

Dr. Foley, do you share those concerns?

Dr. FOLEY. I disagree with the premise of your question in that this new regulation is a gag rule. I also disagree with the premise that healthcare providers are going to be forced to provide—limit the information that they give to their clients that are there. There is nothing in this rule that will preclude that from happening and that is not the intent. The intent is simply to maintain and make sure that this rule is following, is compliant with the statute that has been in place, and with the intent.

Ms. CLARKE. I yield back.

Ms. DEGETTE. The gentle lady's time has expired.

The Chair now recognizes the gentle lady from Florida, Ms. Castor, for five minutes.

Ms. CASTOR. Thank you, Madam Chair.

You know almost 50 years ago America established an important public policy through Title X that birth control, and contraceptives, and family planning should be just as available to working class and uninsured women as they are to every other woman across the country. And despite all the progress we have made and all of the new modern types of birth control that have become available, many women and families still struggle with access to contraceptives, preconception care, and vital health screenings.

Now, the Trump administration wants to pass a rule that takes America backwards, that deemphasizes contraceptives, and birth control, promotes abstinence and the rhythm method. This is something of a battle we fought 50 years ago, isn't it? And what strikes me is that it is clear that this Trump administration proposed rule is going to increase the number of unintended pregnancies. And don't just take it from me, that's what all of our trusted health groups have said; the American Medical Association, the American College of Obstetricians and Gynecologists, the American Public Health Association. Why are they wrong, Dr. Foley?

Dr. FOLEY. I disagree with the premise that this new regulation is going to not emphasize contraceptives and emphasize other methods are more important. That is not what it says.

Ms. CASTOR. Well, America is always at its best when we base policy on science. And Title X—that is particularly true for Title X because it has always been seen as the gold standard for family planning care in this country, based on the best standards of care.

Now this proposed rule is going to change that. Since the year 2000, Title X regulations have stated that services are going to be a broad range of acceptable, and effective, medically-approved family planning methods and services, including natural family planning, right? That's what the regulations have said.

Dr. FOLEY. The current regulation states that.

Ms. CASTOR. So your final rule now would remove the requirement that methods of family planning include those that are, "medically approved." Instead, the rule emphasizes the provision of natural family planning over other methods.

Now America's College of Obstetricians and Gynecologists have said about that, this modification appears to be diluting long-standing Title X program requirements, lowering the standards governing the services that must be offered. These changes threaten the quality of family planning available to Title X patients.

Now, don't just take it from those experts. The American Academy of Family Physicians advised you that in removing medically approved from current requirements, the rule, "allows Title X grantees to exclude certain forms of FDA-approved contraceptives, restricting access to safe and effective contraception."

Did you look at how many more unintended pregnancies will result from this rule?

Dr. FOLEY. I would disagree with the premise that medically approved is an issue.

Ms. CASTOR. Can you just say—can you answer directly? Did you examine how many more unintended pregnancies will result because of the change in policy?

Dr. FOLEY. The——

Ms. CASTOR. Yes or no?

Dr. FOLEY. In the estimation of that, there would not be a change based on any changes made to the rule.

Ms. CASTOR. Well why do you disagree with all of the—I mean who are we going to trust out there, American Obstetricians and Gynecologists, the AMA, the American Family Physicians? They are the ones that have said that this rule will lead to negative health outcomes, it will lead to more unintended pregnancies. That is, unfortunately, going to be the result when you have less contraceptive services, medically—approved, that are available to women and families across the country. You have elevated ideology over evidence in the public health and you have done so to the detriment of women and families.

And I yield back at this time.

Ms. DEGETTE. The gentle lady yields back.

The Chair now recognizes the gentleman from Virginia for five minutes.

Mr. GRIFFITH. Thank you very much, Madam Chair.

Dr. Foley, this does not make it so that there are less contraceptive services unless you include abortion. Isn't that correct?

Dr. FOLEY. That is correct.

Mr. GRIFFITH. So the premise that somehow there is less contraceptive services, unless you are counting abortion, it is just not accurate.

Dr. FOLEY. There is nothing in the rule that would lead to that.

Mr. GRIFFITH. And in fact when I read the code section, it seems pretty clear that if they were doing what the other side of the aisle seems to think they were doing, they were already in violation of the law. Am I misreading the law there? I know you are not a lawyer. You can say I am not a lawyer. It is all right.

Dr. FOLEY. I am not a lawyer.

Mr. GRIFFITH. All right. Well, I am a lawyer and that is the way I read it. It looks like to me if what they are saying is accurate, they were—somebody was violating the law all along.

Speaking about that, there has been a lot of discussion about the co-location requirements. What percentage of Title X clinics are currently in violation of the co-location requirements in the new rule?

Dr. FOLEY. The estimate by a congressional report was that approximately ten percent of the Title X service sites are in co-location. If you look in the preamble, the discussion and the calculations that the Department made to look at economic impact with a physical separation made an estimate that possibly there would be 20 percent. So they increased that to make sure that there was enough of a balance to really properly look at what economic impact there might be for requiring physical separation.

Mr. GRIFFITH. Out of all the thousands of locations, we are talking about somewhere between 10 and 20 percent may be impacted by this. Is that correct?

Dr. FOLEY. That is the estimation, yes.

Mr. GRIFFITH. And my understanding is that co-location requirement is not heavy or heavily onerous. So it is something that most of these locations can probably fix fairly easily. Isn't that also correct?

Dr. FOLEY. Again, that is a determination for those particular entities. I——

Mr. GRIFFITH. But the rule was not interpreted or it was not intended to be overly burdensome, just trying to follow the law. Isn't that correct?

Dr. FOLEY. It is trying to make sure that we are in compliance with the statute, yes.

Mr. GRIFFITH. Amazing an administration wants to follow the statute. Just amazing.

Let me ask you some other questions, if I might. Can you describe the program reviews that HHS uses to audit Title X grantee compliance with the terms of their Title X grants?

Dr. FOLEY. We currently have a number monitoring processes in place. One of them is an extensive program review that occurs once every funding period, where there is an extensive administrative, clinical, and financial audit and review of the grantee, as well as a number of sub-recipients.

Mr. GRIFFITH. So these program reviews do extend to the sub-recipients?

Dr. FOLEY. They do.

Mr. GRIFFITH. OK and——

Dr. FOLEY. Not all of the sub-recipients but there are one or two that are chosen for site visits.

Mr. GRIFFITH. And how frequently does HHS conduct program reviews or other audits of the Title X grantees?

Dr. FOLEY. They are done once a project period. So typically, a grantee would be reviewed once every 2 to 3 years.

Mr. GRIFFITH. OK, so we are not talking about monthly, or quarterly, or anything like that? No.

And what are some of the common findings these audits have had over the last 5 to 10 years?

Dr. FOLEY. When those have been reviewed, there are a number of administrative types of things that have shown up, as far as not reporting different kinds of things. There have been situations where there have been instances where funds have been commingled that have been a citation, again, not to the level of—when something—when we find a citation, typically, we notify the grantee of that. And then they are required to fix whatever that was, and then get back to us about how they have done that, and then we follow up again.

So there have been a number of instances, over the past five years, that have shown misunderstanding with grantees and some sub-recipients as far as what the funds can be used for and not used for.

Mr. GRIFFITH. Now my time is almost up but can you elaborate on your written testimony and tell me how the Protect Life Rule would expand innovation?

Dr. FOLEY. Part of what the requirements in the new rule are that we would extend as part of the application process, that there would be priority given to grantees that show innovation in reach-

ing underserved or unserved populations. And so looking to try to expand beyond maybe where we are having services or we are providing services already.

Mr. GRIFFITH. So the hope is that you will have a greater impact on the communities, particularly the lower income communities.

Dr. FOLEY. Yes.

Mr. GRIFFITH. Yes.

I yield back.

Ms. DEGETTE. The Chair now recognizes the gentleman from New York, Mr. Tonko, for five minutes.

Mr. TONKO. Thank you, Madam Chairwoman.

Dr. Foley, just a point of clarification before I begin my questions. You keep on saying that the rule does not prohibit discussion about abortions. That may be true. However, isn't it true that under the rule a provider can choose to withhold that information?

Dr. FOLEY. That protection is given under the Federal statutes that protect conscience protection.

Mr. TONKO. But so is it true that the provider can choose to withhold that information?

Dr. FOLEY. Under their Federal—yes, under their Federal rights.

Mr. TONKO. Well how you can say the rule preserves open communication if a provider can decide what information to share or which information to withhold from the patient?

Dr. FOLEY. That is actually no different than the way things are currently. Providers still, for a conscience ability, are able to withhold that information now, even under the current regulation. The Department, since those Federal conscience regulations were put into place in 2006–2009, the Department has not held grantees or providers to the standard of having to refer or talk about abortion if they have a conscience objection to it.

Mr. TONKO. So as we are discussing the Title X Family Planning Program today, I think it is imperative that we focus on the fact that the program was created to ensure that low-income women had access to the family planning method of their choice, that they had access to related preventative healthcare, and that they had access to care. Yet, if the administration's new rule were to proceed, according to the American Congress of Obstetricians and Gynecologists, and I quote, "more than 40 percent of Title X patients at risk of losing access to critical primary and preventative care services."

So those at risk include many in my home State of New York, where Title X supported 187 Health Centers that provide care to 306,000 plus New Yorkers. Some of these patients shared their stories with me.

Emily, for instance, from the Capital Region in my district, and I quote, says "the only care that I could receive was from Planned Parenthood. Planned Parenthood was there for me with no judgment. They provided the necessary and affordable medical care that I needed when no one else would."

Jasmine, another constituent, and I quote, "as someone who has benefitted from Title X, my ability to continue seeing the healthcare provider I know and trust is on the line. My healthcare is not a political game. It should not matter who you are, or where

you live, or what kind of insurance you have; every single person should be able to make their own decisions about their healthcare."

I couldn't agree more.

So, Dr. Foley, in your testimony you indicate that a purpose of the rule is to expand coverage and increase the number of clients served within the Title X programs. So, Doctor, has HHS conducted an analysis to estimate the number of patients who stand to lose or gain access to care under your new rule?

Dr. FOLEY. Again, the primary purpose of the rule is to ensure that there is compliance.

Mr. TONKO. No, have they conducted an analysis? I just want that answered.

Dr. FOLEY. There has been a careful analysis of looking at coverage.

Mr. TONKO. Is it a formal analysis? Can you share it with us?

Dr. FOLEY. It is analysis that has been done as the rule was being written. It is analysis that is ongoing. We have every hope——

Mr. TONKO. Well wait a minute. If it is ongoing, why would you go forward with the rule?

Dr. FOLEY. We have every hope that we will not lose grantees already.

Mr. TONKO. You have hope and you have an ongoing analysis. Did you conduct an analysis before you inducted the rule?

Dr. FOLEY. There was analysis done that looked to see, again, what was going to be the effect of this. And our hope was, again, as I mentioned in answering another question, if the grantees that currently co-locate, that they refuse to follow that regulation, that is approximately ten percent of the sites we have currently, in looking at that, there are other clinics in those areas that would be able to take those patients. And so yes, there was that type analysis done.

Mr. TONKO. OK. Well, it doesn't seem like a strong enough analysis, as you described it.

The American College of Physicians, along with other leading medical and health organizations believes that the provisions of the Title X gag rule threaten patients' access to care. They state clearly that, and I quote, "the significant changes to Title X will jeopardize access to healthcare for vulnerable, often working, low-income patients who may have limited to no access to health insurance."

So Doctor, do you still contend that the rule does not place patients' access to care at risk?

Dr. FOLEY. Again, the rule does not preclude full conversation with clients about what they have——

Mr. TONKO. But why are they wrong? Why are these people wrong in their analysis?

Dr. FOLEY. In their analysis, I am not sure. I have not seen that analysis or talked with them. So I am not sure what they are talking about in this situation. However, there is nothing in the rule that forces physicians or healthcare providers to withhold information. There is nothing in the rule that would preclude the full range, broad range of effective and acceptable contraception, family planning methods to be given. It is stated in the rule that is the

requirement, that is the expectation of grantees under this new rule.

Mr. TONKO. Well, I have used up my time. I would hope you would provide evidence to back that claim. And with that, I yield back.

Ms. DEGETTE. The Chair now recognizes the gentleman from South Carolina for five minutes.

Mr. DUNCAN. Thank you, Madam Chair.

You know Republicans are being painted that we are anti-Title X and nothing could be further from the truth. In fact, I am a fan of Title X. There are about 4,000 service sites, I think, in the country that Title X funds. Only about 500 of them are Planned Parenthood.

The argument from the other side is that with this Title X funding, after this rule, that many low-income Americans will no longer have access to the health resources available to them. That is just wrong because there are only 500 Planned Parenthood sites, 4,000 Title X sites. These are Federally Qualified Health Centers, which I am a big fan of. In fact, I think we should have expanded the Federally Qualified Health Centers before we allowed the Affordable Care Act to pass. We should have looked at where the rubber meets the road, where low-income Americans have access to health services on a wide spectrum at the Federally Qualified Health Centers across this country. We should have expanded the Federally Qualified Health Centers across this country, not expanding Planned Parenthood, per se, but places that are meeting the needs of the poor folks in our country.

But when the Government confiscates the tax dollars from Americans, and I think the abortion issue in this country is probably about 50–50, that is just guessing off the cuff here, so 50 percent of the country doesn't want their tax dollars to go to pay for abortion services. And Government takes that money and then uses it to pay for abortions. In fact, Planned Parenthood gets about $50–60 million in Title X funds. Now not 100 percent of that goes to abortion. In fact, I think it is very difficult to determine how much of that tax dollars go to abortion because the money is commingled at Planned Parenthood and some of that money pays for regular health services that Planned Parenthood provides, but some of it pays, commingled money they get from private donors, money they get from tax dollars commingled and they use to pay for all the services that Planned Parenthood provides. And so it is very difficult.

Does the HHS have any concerns about the financial oversight of Title X Planned Parenthood sites and that commingling that I am talking about?

Dr. FOLEY. That is the reason that one of the—that a part of this rule is that there is going to be physical and financial separation in the case where there is co-location because of the—to make sure that there is no commingling of funds, to make sure that there isn't fungibility that is used, and to make sure that there isn't a benefit based on economy of scale, which, again, would be against the Section 1008 of the statute.

Mr. DUNCAN. All right. Do you agree with me that the Federally Qualified Health Centers—take Planned Parenthood out of it for

just a second, but the other Federally Qualified Health Centers actually meet the needs of folks around the country?

Dr. FOLEY. There are a lot of Federally Qualified Health Centers that are part of our Title X network that we work with and that do provide great service.

Mr. DUNCAN. Right. Many have been calling this final rule a gag rule. In a statement released in March by Planned Parenthood, it referred to the final rule as the Trump-Pence administration's unethical, illegal, and harmful Title X gag rule. This could not be further from the truth. It is not the banning of abortion or abortion referral in the private sector, it is only governing programs that the Federal Government funds with tax dollars. As I mentioned earlier, Planned Parenthood chooses to prioritize their abortion services over the rest of the services they provide.

The final rule is very clear, if Title X sites want to continue receiving Federal dollars, they simply must comply with the provisions of the final rule, which are consistent with the original statute. Go back to the original statute. It requires that none of the funds, quote, "in Section 1008 of Title X says that none of the funds appropriated under this program shall be used in programs where abortion is a method of family planning." That is in the statute. That is not my words. That is in the statute.

And so the rule is clear. It says that if Title X sites want to continue receiving Federal dollars, they simply must comply with the provisions of the final rule, which are consistent with the original statute. Wouldn't you agree with that? If not, they will have to seek their own private funding to continue the services, wouldn't they?

Dr. FOLEY. I am not aware of what their financial situation is.

Mr. DUNCAN. Right. Also under the final rule, grantees are permitted, just no longer required, to provide nondirective pregnancy counseling, including nondirective counseling on abortion to their patients. Isn't that right under the rule?

Dr. FOLEY. That is a stamp yes.

Mr. DUNCAN. And can you go into further detail on how this is different from the original 1988 policy?

Dr. FOLEY. The 1988 regulation actually was more restrictive, in that it prohibited any counseling about abortion and it also prohibited referral for abortion. Again, the Supreme Court upheld that as consistent, both from a statutory as well as a constitutional standpoint, that that particular one stood that test.

However, we believe, as we were looking at this rule, that we needed to make sure that health professionals were able to have conversations with their clients that they wanted to have.

Ms. DEGETTE. The gentleman's time has expired.

Mr. DUNCAN. Thank you very much. I yield back.

Ms. DEGETTE. The Chair now recognizes the gentleman from Massachusetts, Mr. Kennedy, for five minutes.

Mr. KENNEDY. Thank you, Madam Chair.

And Dr. Foley, you said that the goal of this proposed rule is to maintain and make sure that the rule is compliant with the statute. Is that right?

Dr. FOLEY. To maintain the statutory integrity.

Mr. KENNEDY. OK. So on the Office of Public Affairs—Office of Population Affairs Web site, your office measures performance based on the effectiveness of contraceptive care and the access to long-acting reversible contraceptive care, LARCs. Do you have any evidence whatsoever that imposing a rule that will likely shutter essentially family planning clinics, which you have estimated to be 10 to 20 percent of them and largely in underserved communities, would force others to forego Title X funding and increase access to LARCs?

Dr. FOLEY. The idea that——

Mr. KENNEDY. Any evidence?

Dr. FOLEY. The evidence that we have is from the 500,000 comments that we received. And of those comments, there were a number of them, providers, who stated that part of the reason why they were not involved with Title X was based on the requirement to refer for abortion.

Mr. KENNEDY. So you read——

Dr. FOLEY. And if that was——

Mr. KENNEDY. Ma'am, reclaiming my time. How many of those 500,000 comments did you look at?

Dr. FOLEY. I looked at most of them.

Mr. KENNEDY. And you didn't have time, based off of your testimony to Mr. Tonko, didn't have time to look at a letter from the American College of Obstetricians and Gynecologists, or the AMA, or the American Academy of Family Physicians. You didn't look at those?

Dr. FOLEY. I did read those letters.

Mr. KENNEDY. You did. So when you indicated to Mr. Tonko that you weren't aware of why every one of these groups is against it, you said you weren't familiar with their analysis, did you look at them or did you not?

Dr. FOLEY. I read the letters.

Mr. KENNEDY. And so are you familiar with why they are against the analysis, why they are strongly, according to the AMA, strongly opposed to the final rule?

Dr. FOLEY. What I said was that I disagreed with the premise upon which that they base their statement.

Mr. KENNEDY. And so those three leading organizations are not—have not approached—there is an issue with the way in which they, all three of them, conducted their studies?

Dr. FOLEY. The issue that this was a gag rule, specifically.

Mr. KENNEDY. The issue that—and that is the only reason why you believe that they are against the existing—this rule is because of the gag rule function. It has nothing to do with the closure of the 10 to 20 percent of the hospitals—of the clinics across the country.

Dr. FOLEY. That, in addition.

Mr. KENNEDY. In addition but you have also spent the last hour-plus saying that there is no major change in this existing rule from the existing law that is already out there. Yet, you indicated that the prior, the violation of this commingling, of which you have offered zero evidence of, zero evidence, the evidence of that was such a grave violation of that before and prior to this rule you offered a letter to work with them to try to address the commingling, and

now we are closing 10 to 20 percent of the clinics across the country? That is the remedy? We are shifting from a letter to closure. That is the appropriate response?

Dr. FOLEY. The choice to close is not of the Department. The choice to close is of the individual——

Mr. KENNEDY. Aside from the fact, ma'am, let's address that next point as well. You have indicated that you are not aware of the financial circumstances of these clinics, yet Kaiser Family Foundation has pointed out that it would cost up to a quarter of the existing budget of the entire program to come into compliance with the rule, a quarter.

So are you familiar with that analysis?

Dr. FOLEY. We disagreed with the premise of that discussion.

Mr. KENNEDY. So you disagree with Kaiser, ACOG, AMA, and American Academy of Family Physicians. Let's see who else you disagree with.

You indicated that you were unaware of the financial circumstances provided by these clinics. Are you aware of the financial circumstances of the American public, yes or no?

Are you aware of the fact that 40 percent of the American public cannot come up with money to spend $400 for an emergency medical bill? Yes or no?

Dr. FOLEY. Can you repeat that question for me?

Mr. KENNEDY. Did you know that 40 percent of American families cannot afford an unexpected $400 medical bill?

Dr. FOLEY. Yes.

Mr. KENNEDY. Did you know how many Americans would drop below 150 percent of the Federal poverty line if you subtracted out the cost of medical care?

Dr. FOLEY. I am not aware of that.

Mr. KENNEDY. Seven million.

Do you know the percentage of clients who rely on Title X sites are now either poor or low income?

Dr. FOLEY. At our last report, approximately 60 percent of our——

Mr. KENNEDY. The data I have is 87 percent.

Dr. FOLEY. That——

Mr. KENNEDY. And so your data is 60 percent. My data is 87 percent. We are closing a rule that you say doesn't actually address any major change in law, that four major medical associations are against, that targets directly low-income individuals' access to critical family care, you are saying is just not that big a deal.

Dr. FOLEY. We are not aware nor in the 500,000 comments that we got was there sufficient evidence to show that these would all close as well. Again, it was——

Mr. KENNEDY. Aside from the studies that I pointed out. No——

Dr. FOLEY. Again, it was an estimation of what might happen and there was not sufficient evidence to show what would happen as a result of this.

Mr. KENNEDY. So ma'am, does your organization take a position on repealing the ACA mandate that contraception be available with no patient out-of-pocket costs and do you have an analysis as to how that would impact access to LARCs?

Dr. FOLEY. The statute requires that for clients who are 100 percent or below the Federal poverty level, that the contraceptive broad range are given to them at no cost.

Mr. KENNEDY. You support the mandate. You support the mandate.

Dr. FOLEY. And then again, there is a sliding fee scale for those above 100 percent.

Mr. KENNEDY. Do you support the mandate, yes or no?

Dr. FOLEY. We support what is in the statute, as well as required by Title X.

Mr. KENNEDY. And how about a $1.5 trillion cut to Medicaid, do we think that that increases women's access to long-term planning or long-term contraception care or no?

Dr. FOLEY. That again, is beyond the scope of the Title X program.

Mr. KENNEDY. And how about the 14 States that have not yet expanded Medicaid? Would expanding Medicaid actually help women gain long-term access to care, yes or no?

Dr. FOLEY. Again, that is out of the scope of what the Title X program is in charge of.

Mr. KENNEDY. I am sure it is.

Ms. DEGETTE. The Chair now recognizes the gentle lady from New Hampshire, Ms. Kuster, for five minutes.

Ms. KUSTER. Thank you, Madam Chair and thank you to our witness for appearing before us today.

You have talked about confusion. And frankly, I think you are adding to the confusion, if you will. But I want to know, because it seems to me that this would require a physician to be omniscient, in a sense. Tell me the protocol for determining whether an abortion is sought, "for purposes of family planning." Walk me through. What would the question be? And just let's use as an example, a 13-year-old raped by her father.

Dr. FOLEY. Again, the regulation allows for referral for abortion in the case of——

Ms. KUSTER. I am just asking you as a physician.

Dr. FOLEY [continuing]. Rape or incest.

Ms. KUSTER. As a physician—okay, so let's say it wasn't rape and it wasn't her father, it was the neighbor. The neighbor having sex with the 13-year-old resulting in a pregnancy. And walk me through, as a physician, the protocol for you to make the omniscient determination that this is for the purposes of family planning.

Dr. FOLEY. What the rule states and, again, the statute states in regulation——

Ms. KUSTER. Just walk me through the protocol.

Dr. FOLEY [continuing]. It does say that if it is not a medical emergency——

Ms. KUSTER. Right, and how would you determine——

Dr. FOLEY [continuing]. Then it is a method of family planning.

Ms. KUSTER [continuing]. This for the purposes of family planning?

Dr. FOLEY. If it is——

Ms. KUSTER. This is the first abortion, the second abortion, the third abortion, what is using abortion for family planning?

Dr. FOLEY. For anything other than medical emergencies or in the case of rape or incest.

Ms. KUSTER. OK. And in those cases, it is prohibited to make a recommendation. You said—you talked about this nondirective. You said if the patient asks. I am talking about a 13-year-old. Like she probably doesn't even know how the pregnancy occurred. Why would she ask? What would she know to ask?

Dr. FOLEY. Following what the statute says in Title X clinics—again, this doesn't restrict anything that a doctor can do outside of Title X-funded programs.

Ms. KUSTER. Well, frankly——

Dr. FOLEY. And what that says——

Ms. KUSTER [continuing]. They are going to close without the Title X funding. I mean you have taken care of that.

Dr. FOLEY. There is no evidence that shows that they will close.

Ms. KUSTER. So in my—I have a rural community. They would not be able to. They can't afford—this whole question of commingling, and we have heard a number of times today that there is virtually zero evidence. You have not cited any evidence of commingling of funds.

So meanwhile, they can't afford to have two different sites. So trust me, they are going to close. And there is no other option in my district. These are rural communities. They cannot get there.

Are you aware that in a rural community where I live there is no childcare up to 6 months? Are you familiar with that?

Dr. FOLEY. I am not familiar with New Hampshire, no.

Ms. KUSTER. And are you familiar that when you have a child, and you live in a rural area, and most of the people working there do not have any paid medical leave, so they do not have any place for the child to be cared for by someone else, nor can they probably afford it if they are working on the typical wage there and the childcare is going to cost them 40, 50, 60 percent of their monthly wage.

So what about the circumstance where they just simply can't afford to have a child? Is that a conversation? Say it is an older person. Say it is someone in their 20s. Say it is one of my nieces, working, unable to afford to have a child, or unable to find childcare for that child, can that conversation include how to make a determination about the pregnancy? Does it include adoption? Does it include terminating the pregnancy? What are the options that you can discuss?

Dr. FOLEY. You can discuss with that client all of the options that are available to them as the pregnancy——

Ms. KUSTER. But only in a nondirective way. So only if the client asks the right questions——

Dr. FOLEY. No.

Ms. KUSTER [continuing]. Not if you think that this is——

Dr. FOLEY. Nondirective means that you can—you give the options to them and then you answer the questions they have. Directive means—you don't direct them, support, encourage one or the other. That is nondirective.

Ms. KUSTER. Let me ask you about that because does this new rule include, say for example, a church program and the only op-

tions that they offer are the rhythm method or abstinence. Is that appropriate under this rule?

Dr. FOLEY. Only if they also——

Ms. KUSTER. They would get Federal funding?

Dr. FOLEY. Only——

Ms. KUSTER. They could get my tax dollars in Federal funding?

Dr. FOLEY. Only if they are associated within their project with other locations that provide the rest of the broad range.

Ms. KUSTER. So that would be OK.

Dr. FOLEY. The rest of the broad range.

Ms. KUSTER. A church that only offered the rhythm method and abstinence, that would be sufficient counseling for a person. And is there a medical exception to that or we will go back to the rape and incest?

Dr. FOLEY. That, again, is under the current regulation, the 2000 regulation allows for entities to provide only one method, as long as they are associated——

Ms. KUSTER. I think there is a lot of confusion.

Ms. DEGETTE. The gentle lady's time has expired.

Ms. KUSTER. I think this is more confusion but I yield back.

Ms. DEGETTE. The Members of the subcommittee now have finished their questioning. And so we thank other members for coming to waive on and for their interest in this topic.

And the first I will recognize is Mr. Shimkus for five minutes.

Mr. SHIMKUS. Thank you, Madam Chair. I am appreciate you letting us waive on. And for the record, Diane DeGette and I are pretty good friends. Sometimes we disagree but in this era of tenseness in Washington, I think that's important to put on the table.

Dr. Foley, thank you for your service. And Joe Kennedy is a good friend of mine, too, but I would ask you, do you know that we have the lowest unemployment since 1969 in this economy? We do. Do you know that the tax cuts passed provided almost $3,000 for a family with two kids? We do. Do you know that unemployment is at 3.6 percent, which is almost, by economists' standards, full employment? The answer is that is a fact. So better wealth, income for our citizens helps across the board.

I also want to take this time, because I had to pull up your bio or parts of it, because you are a compassionate doctor in this field. Originally from Indiana, Dr. Foley founded and served as medical director of Northpoint Pediatrics. Shortly after completing a residency in pediatrics, Dr. Foley's areas of special interest are adolescent gynecology, prevention and treatment of sexually transmitted diseases, healthy family formation, and global health.

Most recently, she was in part-time clinical practice at Certified Centers for CMS, a critical access hospital in Lamar, Colorado. At the same time Dr. Foley served as Director of Medical Ministries for Global Partners of the Wesleyan Church, where her responsibilities included oversight of mission hospitals in Sierra Leone, Zambia, and Haiti. Dr. Foley is a graduate of Marion College, now Indiana Wesleyan University, and the Indiana University School of Medicine.

Sometimes I think it is important to know people's background. We get in a hyper partisan event, although this hearing has been

conducted respectfully and I attribute that to the Chair and her demeanor.

A couple questions. What is the—what are some of the—because this commingling of funds and this co-location issue has always been a debate in this arena. What are some of the ways Title X grantees may spend the funds available to them?

Dr. FOLEY. The funds that are used in Title X programs must be used to provide a broad range of effective and acceptable family planning methods and including associated preventative services as well. So in addition to providing contraception, to providing training on natural family planning methods, they also can be used for screenings that are related to health, such as screening for sexually transmitted infections, such as cancer screenings—

Mr. SHIMKUS. Let me ask, because I filibustered and used a lot of my time, how are these types of expenses tracked?

Dr. FOLEY. They are reported to the Federal Government and there are reports that have to be turned into the grant office.

Mr. SHIMKUS. Let me ask another question. May Title X grantees count clients as Title X clients and also bill Medicaid for services provided to the client?

Dr. FOLEY. Yes.

Mr. SHIMKUS. In the Clinton era, Title X regulations put an emphasis on privacy to the exclusion of parental involvement, despite the statute and annual appropriation bills putting emphasis on parental involvement. How does this rule improve family involvement and communication?

Dr. FOLEY. Again, the statutory and the appropriations have mandated that there needs to be family involvement. And what we have done is just require that there is a way within the patient record that it is notified that they encourage that. Again, we cannot require that there is parental consent. That is not within our purview. However, using the best adolescent development information we know now, and in fact there was a study that was just released——

Mr. SHIMKUS. OK, let me go. You are doing great. I have got one more I need to get in.

You mentioned 2009 in this conscience protection discussion we had earlier. Who was the President at that time? President Barack Obama.

Dr. FOLEY. It was the last administration.

Mr. SHIMKUS. So conscience protection is very important in this whole debate and it shouldn't be discarded.

With that, Madam Chair, I will yield back my time.

Ms. CASTOR. [presiding]. Mr. Luján, you are recognized for five minutes.

Mr. LUJÁN. Thank you, Madam Chair. I want to thank you and the ranking member for this important hearing.

Dr. Foley, thank you for being with us today. Dr. Foley, yes or no, are you a medical doctor?

Dr. FOLEY. I am.

Mr. LUJÁN. Are you familiar with both AMA's Code of Medical Ethics and the AMA's comments on the rule?

Dr. FOLEY. Yes.

Mr. LUJÁN. Do you agree with the AMA that this rule will cause doctors to violate medical ethics by limiting their ability to counsel their patients about all of their options and to provide referrals?

Dr. FOLEY. What I—I do not agree that this rule limits their options to be able to talk with the patients about all. It does not limit their ability to talk about all of the options.

According to the statute, referral is not—is prohibited. However, all along, Congress, as well as other bodies, have separated, and the AMA also separates out counseling from referral. Those are two different types of things.

And so from a medical/ethical standpoint, I firmly believe physicians need to be fully able to have full and open conversations with their clients about all of the different options and provide that information to their patients in an ethical way. It is mandated, again by Congress, that that is done non-directively, in that information is given, questions are answered, however, one method is not—we don't direct them to make one method over another. There is not one that is encouraged more than another.

Mr. LUJÁN. Dr. Foley, would you agree that the American Medical Association essentially wrote the book on medical ethics? Is that a fair statement?

Dr. FOLEY. I would say that there are—there may be—it certainly is the medical body association. There are a number of people, and we found that from the 500,000 comments that we got, that disagree that this rule is in violation of medical ethics.

Mr. LUJÁN. Do you disagree with the AMA's Code of Medical Ethics? You said you were familiar with them.

Dr. FOLEY. I disagree with the premise of the question that this rule violates that.

Mr. LUJÁN. No, no, that is not what I am asking. That is not what I am asking.

Do you disagree with AMA's Code of Medical Ethics? You said you were familiar with them when I asked the question initially.

Dr. FOLEY. Yes, I do not disagree with that.

Mr. LUJÁN. You do not disagree with AMA's Code of Medical Ethics.

Dr. FOLEY. Yes.

Mr. LUJÁN. I heard you say yes. Is that correct?

Dr. FOLEY. Yes.

Mr. LUJÁN. Well here is what the AMA said about this rule, and I quote, "the inability to counsel patients about all of their options in the event of a pregnancy and to provide any and all appropriate referrals, including for abortion services are contrary to the AMA's Code of Medical Ethics."

Dr. FOLEY. And what I would say is I disagree with the premise that this rule violates that.

Mr. LUJÁN. Dr. Foley, the folks that wrote the rule, that have a responsibility to make sure that these medical ethics are not being violated are talking about the concerns that they have. I think it is the premise of the question that you have been asked by several of our colleagues today. And so if you do not object to the AMA's Code of Medical Ethics, I think that we should listen to the experts from the AMA when they say that they have a concern that the

AMA's Code of Medical Ethics are going to be violated. That is what you are requiring doctors to do.

So my concern is that it would appear that HHS would be putting providers in the impossible position of choosing between their patients' rights or what the Government dictates. According to the AMA, before HHS issued the final rule, Title X providers were required to advise their patients about their healthcare options according to the patient's interests. That is medical practices and accepted standards of professional ethics under the final rule. However, Title X providers are no longer held to such standards, closed quote.

Why is this administration comfortable lowering the standards of provider care and dictating what can and cannot be said in a doctor's office?

Dr. FOLEY. I disagree with the premise of that. There is nothing in the final rule that will not allow a physician to have that full conversation with their clients. That is not part of what the rule states.

Mr. LUJÁN. So you stand by saying that the gag order that is being put in place by this administration does not restrict the conversation that doctors can have. That is what you are saying. That is your interpretation.

Dr. FOLEY. That is true.

Mr. LUJÁN. And you would fight to protect that in court? So if you a doctor violated your rule and had a conversation in court, you are saying that they are not in violation?

Dr. FOLEY. I am not a lawyer. I am here representing what the rule says.

Mr. LUJÁN. You are the expert. This is your responsibility.

Dr. FOLEY. I am an expert as a physician and you asked me about the ethics.

Mr. LUJÁN. All right.

Dr. FOLEY. I would say to you that this rule does not violate those ethics.

Mr. LUJÁN. Well, Madam Chair, as my time expired, I think there is a bit of a conflict here because what I just heard was that the rule does not restrict any physicians from having these conversations. I hope I can get that in writing so that we can give that direction. Because the way that I read this and the AMA reads this, there is a gag order that is being put in place and restrictions being put in place.

And with that, I yield back.

Ms. DEGETTE. [presiding.] The Chair now recognizes the gentleman from Ohio——

[Disturbance in hearing room.]

Ms. DEGETTE. The committee will come to order.

The Chair will now recognize Mr. Latta from Ohio for five minutes.

Mr. LATTA. Well thank you very much, Madam Chair and thanks very much for allowing me to participate in the hearing. I really appreciate it. And thanks to our witness for being here today.

Dr. Foley, the final rule requires that all Title X clinics provide annual training for staff to ensure compliance with State reporting

laws for child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, and trafficking.

Are the new rape and abuse reporting requirements different from those in the old Title X rule?

Dr. FOLEY. The current regulation does not state what Title X providers or grantees are required to do to show that they followed the mandate that says that they need to be reporting according to State laws.

So what this new regulations has done is put into place the process requiring annual training and then requiring the recording of the fact that they are following that mandate.

Mr. LATTA. You know when you say the annual training, has there been a requirement for annual training in the past?

Dr. FOLEY. No, that has not been in regulation. That has been a practice that the Title X program has had and is recommended in quality family planning but has never been put in as far as something that is required that would need to be reported upon.

Mr. LATTA. OK, thank you.

We had a little discussion here about the gag rule and some have called this a gag rule, which implies that freedom of speech is being impinged. Does this rule impact what grantees may do at locations not funded by Title X programs?

Dr. FOLEY. Not at all.

Mr. LATTA. And do grantees who don't agree with the Protect Life Rule have the freedom to forego taxpayer dollars and seek private funding instead and elsewhere?

Dr. FOLEY. Yes, it simply is putting restrictions on how Federal funds can be used.

Mr. LATTA. OK. In 2015, Planned Parenthood served 2.4 million clients and 1.6 million of these clients received Title X—were Title X patients, meaning that 67 percent of Planned Parenthood clients were Title X clients served by a program that makes up just four percent of their total $1.46 billion in revenue.

How do we or you reconcile these numbers? Is there a way to reconcile that and is it possible that clients are counted as receiving Title X services when they are also receiving services funded under other federally or privately funded type programs?

Dr. FOLEY. Most of our grantees—we do not have enough funding to fund family planning services that our grantees and our sub-recipients need. And so most of them have a variety of other funds that help to fund the services that they have. So that is likely what has happened as a result of that.

Mr. LATTA. Just backing up, would there be any other federal dollars out there did you say?

Dr. FOLEY. Medicaid is the primary, actually would be the primary funding source for most of our Title X clients because it is a service reimbursement.

Mr. LATTA. OK.

Well thank you very much, Madam Chair, and I yield back.

Ms. DEGETTE. The Chair now recognizes Mr. Bilirakis for five minutes.

Mr. BILIRAKIS. Thank you, Madam Chair. I appreciate it so very much.

And I want to thank the chair, Ms. DeGette, and also my good friend from Florida, my neighbor, Ms. Castor.

But Dr. Foley, I have a couple questions. Title X is the only Federal program dedicated solely to the provision of family planning and related preventative healthcare. What services are encompassed under the Title X program?

Dr. FOLEY. The Title X program is authorized to provide voluntary family planning projects. They must offer a broad range of acceptable and effective family planning methods and services and, in addition, related preventative services, those that relate to family planning, which is to help prevent pregnancy or to help to achieve a pregnancy. So that would include or could include things that might affect infertility, sexually transmitted infection screening, cancer screening, those types of things; basic infertility services.

Mr. BILIRAKIS. OK, very good.

While Title X is the only program dedicated solely to this purpose, as you said, what other federal programs also provide services for family planning and related preventative healthcare?

Dr. FOLEY. There——

Mr. BILIRAKIS. If you could give me an example or give me a few. Yes.

Dr. FOLEY. There aren't any that strictly provide just family planning services. Again, Medicaid is a reimbursement service, so that would be another Federal program that would help to cover that.

Mr. BILIRAKIS. OK, but there are alternatives out there and Medicaid does cover those programs.

Under the proposed Title X rule, the amount of funding available for family planning would not diminish. I am pretty sure that is correct. It would only be redirected away from providers so determined to provide abortion that they refused to comply with the new rules.

Under the Clinton era regulation, Title X grantees were required to refer for abortion. Is that correct?

Dr. FOLEY. If the patient requested that, they were required to refer for abortion.

Mr. BILIRAKIS. OK, what does this mean for entities that want to provide care without referring for abortion because it goes against their moral convictions or religious beliefs, and how would the new rule change that, the Trump rule?

Dr. FOLEY. The new rule that is currently enjoined states that because—that referrals for abortion are prohibited, except in the case of medical emergencies, or rape, or incest. So for family planning, for the purpose of family planning, referral for abortion is prohibited as a part of that program.

Mr. BILIRAKIS. So we are basically going back to prior 2000. Is that correct, to a certain extent?

Dr. FOLEY. Consistent with the 1988 regulations.

Mr. BILIRAKIS. To 1988, OK, very good.

I yield back, Madam Chair. I appreciate it very much.

Ms. DEGETTE. The Chair thanks the gentleman.

And now the Chair recognizes the gentleman from Montana for five minutes.

Mr. GIANFORTE. Thank you, Madam Chair.

And Dr. Foley, thank you for being here today. You testified earlier that, under this new rule, providers would not be restricted from fully counseling their clients on the range of options. Is that correct?

Dr. FOLEY. That is correct.

Mr. GIANFORTE. Yes, and I just wanted—there was some dispute here earlier with some of the interaction. I just I was looking at the rule itself. And just reading directly from the rule it says Title X provider may provide a list of licensed, qualified, comprehensive primary healthcare providers, including providers of prenatal care, some of which may provide abortion, in addition to comprehensive primary care. So it seems that the actual rule verifies what you testified in front of this committee. So I just wanted to set that clear in the record that it does not restrict doctors in any way from discussing a full range of options.

As you know, Montana is an incredibly rural State. Most parts of Montana are still considered frontier areas. Providing medical care there is more difficult because of just the expanse. This makes accessing family planning services incredibly difficult for the women in our State.

So one of the goals, as I understand, in the Protect Life Rule, is to increase innovation, expand diversity of grantees, and to clarify the flexibility the program directors have to provide services. Do you think that this new rule will help promote a diversity of grantees under Title X?

Dr. FOLEY. That is what we are hoping for. In addition, again, this is a competitive grant application. And so it depends on the people who apply for this grant to provide services. However, what the new rule does allow for is innovation in providing services to areas that are unserved or underserved and increasing the emphasis on those areas, looking for grantees who are willing, or who are located in those areas, and would like to provide service.

Mr. GIANFORTE. So what, specifically, would this new rule, what impact would it have on rural areas in the United States?

Dr. FOLEY. The idea would be that if there are—if current grantees even would look for sub-recipients that maybe in more rural areas and expand their services in that area, that would impact the access for rural areas.

Mr. GIANFORTE. So this new rule, in your opinion, would expand access to services for women in rural areas.

Dr. FOLEY. With that emphasis, yes.

Mr. GIANFORTE. OK. So what impact, if any, will this diversity in grantees have on helping ensure the Title X program is serving patients in these underserved areas?

Dr. FOLEY. Again, by emphasizing those that are providing or suggesting innovative ways to provide services to underserved areas, we would be able to focus our funding in those areas.

Mr. GIANFORTE. OK. And this is a real priority for me, particularly in a rural State like Montana.

So a question of the difference between the prior rule and this new rule, could an entity that had a conscience objection to certain Title X services required under the 2000 regulation participate in the program?

Dr. FOLEY. They could participate in the program. In fact, the Department has issued guidelines that because—the regulation was written before some of these conscience guidelines came into effect. And so when the Federal conscience guidelines were in effect, the Department has stated, and it has been long-standing, that they cannot require someone to refer for abortion, counsel about abortion, if they have a moral objection to that.

Mr. GIANFORTE. OK. And how does that change under the new rule?

Dr. FOLEY. Well in the new rule, the referral for abortion is prohibited. Again, the same conscience protection. The Federal conscience protections don't change but there has been confusion surrounding the fact that if it states it in the regulation that you must refer for abortion and you must counsel about abortion, even if you have conscience concerns about it. There has been confusion that they would still be able to participate.

Mr. GIANFORTE. OK.

Dr. FOLEY. And so I think that clarifies and makes that—brings those into line.

Mr. GIANFORTE. OK, thank you, Dr. Foley. I would just say, based on what we have heard here today from your testimony, also from a reading of the rule, this new rule does not restrict a doctor's ability to provide all options to their patients and, in fact, the rule will help particularly in bringing additional services to women in rural areas of the country. So I thank you for your work on it and I appreciate your being here.

With that, Madam Chair, I yield back.

Ms. DEGETTE. The gentleman yields back.

Dr. Foley, I want to thank you for coming today. I just have one last piece of housekeeping that I hope you can help me with.

This committee has sent four letters to Secretary Azar starting January 29, 2018 regarding the Title X program. We got a response, finally, on April 17th of this year, and thank you. Your agency started providing documents.

But here is the problem. These are the kinds of documents we are getting. You can see I have page after page of documents that have been completely redacted. And we understand there is some pending litigation but we haven't gotten justification on why each particular document was redacted.

And so I bring this up because it has been a pattern with HHS in general of not getting documents and then getting documents that are redacted. And so since you signed the initial letter producing documents and most of the documents lie within your agency, will you commit to working with this committee to provide as many unredacted documents as possible and to explaining why certain documents have been redacted?

Dr. FOLEY. We will be able to provide explanation for you. What we have done is we have followed the Federal laws as far as information that is privileged and information that might be involved with litigation and that has been the reason for it. However——

Ms. DEGETTE. That is——

Dr. FOLEY [continuing]. We will look at that again and we will get back with you.

Ms. DEGETTE. I appreciate that. You know that is the reason that was given but, again, it wasn't given for each particular document. And so if you can work with us, that would be great.

I do see that Mr. Veasey has joined us and I will, since I have given comity to all of the witnesses, I thank you for coming, Mr. Veasey. And we will just recognize him for five minutes and then we will let you go.

Mr. VEASEY. Thank you, Madam Chair.

Dr. Foley, with seemingly every major national provider organization sounding the alarm, HHS finalized the rule with the most disconcerting provisions intact.

Nineteen leading women healthcare provider groups, medical organizations, and physicians have stated that, "this regulation will do indelible harm to the health of Americans and to the relationship between the patients and their providers by forcing providers to omit critical information about their healthcare resources and current requirements that Title X sites—excuse me—and for the reasons discussed in more detail and in our court complaint, the AMA strongly opposes the final rule. We are very concerned that the proposed changes, if implemented, would undermine patients' access to high-quality medical care and information, dangerously exclude qualified providers, and jeopardize public health."

"In addition to the legal arguments that the final rule be permanently overturned by the Federal courts, the AMA urges Congress to swiftly take legislative action to prevent further attempts by the administration to jeopardize the critical Federal healthcare program."

Dr. Foley, I wanted you to weigh in, when it comes to the patients' confidence and some of the things that I have just mentioned earlier, to please tell us why this rule would not interfere with the patient-provider relationship, will not cause providers to violate ethical standards, and will not put improper restrictions on the practice of medicine, and does not put ideology over science, and will not jeopardize public health as experts have stated.

Are all of these medical organizations wrong?

Dr. FOLEY. What I would say is that the rule was written and revised to allow complete full conversation, allow physicians, healthcare providers, to have complete conversation with the clients about the options that they have. There is no restriction on that.

I would also say that this rule was written very similar to the 1988 rule that was written and that rule was then upheld by the Supreme Court that it did not violate statutory or constitutional standards. And in addition, that they did not—they also stated that it did not violate the Code of Medical Ethics based on what this—based on their interpretation of that.

Mr. VEASEY. Dr. Foley, I think that this is—so, are you saying that they are wrong?

Dr. FOLEY. What I am saying is——

Mr. VEASEY. You really didn't answer my question. So, are they wrong?

Dr. FOLEY. What I am saying is that this rule, this new regulation, does not force physicians to omit information. There is noth-

ing in this new rule that omits them—that causes them to force—to omit information.

Mr. VEASEY. OK, so you are not saying—you are not answering the question about whether they are wrong.

Ms. DEGETTE. Will the gentleman yield?

Mr. VEASEY. Yes.

Ms. DEGETTE. It doesn't force them to omit it but allows them to omit it, correct?

Dr. FOLEY. And the allowing them to omit is based on the Federal conscience statutes that, again, preclude the law. And that is what is important to understand.

Mr. VEASEY. Dr. Foley, it is just hard to put a lot of stock into what you are saying today. Numerous medical and public health organizations have detailed how this rule will lead to negative health outcomes. They have stated that the rule will result in less contraceptive services, more unintended pregnancies, which is a big problem in the district that I represent in Dallas right now. We are seeing rates go down in other parts of the country but we have seen a steep increase in STDs and unplanned pregnancies in the Dallas area. And I just think that HHS is putting ideology over evidence and public health.

I yield back my time.

Ms. DEGETTE. I thank the gentleman. And again, Dr. Foley, I thank you for joining us today. We will look forward to getting your documents. And with that, you are dismissed.

The Chair will call up the next panel.

Dr. FOLEY. Thank you.

Ms. DEGETTE. The committee will come to order and the witnesses will take their seats.

The Chair will advise members, while we are waiting for Dr. McLemore, that we are expecting a series of votes around 1:00 or 1:15 and it will be, unfortunately, a very long series of votes. I had hoped to be able to finish this panel but I think that probably we may have to have the member questions after we return. So I just wanted to let you know that.

The Chair will now introduce our second panel of witnesses and welcome all of you. Thank you so much for your patience. Ms. Clare Coleman, the President and Chief Executive Officer of the National Family Planning and Reproductive Health Association; Ms. Kami Geoffray, the Chief Executive Officer of the Women's Health and Family Planning Association of Texas; Monica McLemore, the Chair-Elect of the Sexual and Reproductive Health Section of the American Public Health Association; Jamila Perritt, M.D., Fellow, Physicians for Reproductive Health; and Ms. Catherine Glenn Foster, President and Chief Executive Officer of the Americans United for Life.

Thanks and welcome to all of the witnesses. As all of you are aware, we are holding an investigative hearing and so, when doing so, we have the practice of taking testimony under oath. Do any of you have any objections to testifying under oath today? Let the record reflect the witnesses responded no.

The Chair will then advise you, under the rules of the House and the rules of the committee, you are entitled to be accompanied by

counsel. Do any of you desire to be accompanied by counsel today? Let the record reflect the witnesses responded no.

And so if you would, could you please rise and raise your right hand so you may be sworn in?

[Witnesses sworn.]

Ms. DEGETTE. You may be seated. Let the record reflect the witnesses have responded affirmatively.

And you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the U.S. Code.

The Chair will now recognize our witnesses for a 5-minute summary of their written statements. As I explained to the last panel, you have a microphone and then you have lights. And the light turns yellow when you have one minute and red when your time is at the end.

And so first I would like to recognize Ms. Coleman for purposes of an opening statement, five minutes.

STATEMENT OF CLARE COLEMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; KAMI GEOFFRAY, CHIEF EXECUTIVE OFFICER, WOMEN'S HEALTH AND FAMILY PLANNING ASSOCIATION OF TEXAS; MONICA MCLEMORE, PH.D., MPH, CHAIR–ELECT, SEXUAL AND REPRODUCTIVE HEALTH SECTION, AMERICAN PUBLIC HEALTH ASSOCIATION; JAMILA PERRITT, M.D., MPH, FELLOW, PHYSICIANS FOR REPRODUCTIVE HEALTH; AND CATHERINE GLENN FOSTER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICANS UNITED FOR LIFE.

STATEMENT OF CLARE COLEMAN

Ms. COLEMAN. Thank you, Chairwoman DeGette. Thank you, Ranking Member Guthrie and the members of the subcommittee for the opportunity to testify.

I am Clare Coleman. For nearly 10 years—closer—for nearly 10 years, I have been the President and CEO of the National Family Planning and Reproductive Health Association, known as NFPRHA. Founded the year after Title X's enactment, NFPRHA advances and elevates the importance of family planning in the Nation's healthcare system. NFPRHA represents the vast majority of Title X providers, with members in all 50 States, DC, and the territories.

Title X plays an essential role in ensuring access to high-quality family planning and sexual healthcare in our country. Congress created Title X to equalize access to biomedical contraceptives and related medical care, and to ensure that those services were voluntary and confidential. These purposes remain Title X's focus 50 years on.

Today, Title X helps more than four million people access contraception and related health services at nearly 4,000 Health Centers across the country. For many, Title X services are the only source of healthcare of any kind, offering patients healthcare they need, exams and contraceptives, sexually transmitted disease testing and treatment, cancer screenings, and information and counseling, including referrals to care outside the scope of Title X.

Title X provider networks are designed by communities for communities to facilitate access to care in the service area covered by the Title X grant. So the network includes State, city, and local health departments, Federally Qualified Health Centers, free-standing family planning providers, Planned Parenthood affiliates, hospitals, and school-based and university-based health centers.

But because Title X is a funding stream, there is no Title X sign on a health center door. Instead, patients know they are in a Title X center by the patient-centered and culturally responsive care they receive from a broad range of FDA-approved methods available on-site to the thorough and nondirective counseling offered.

Title X standards of care are the gold standard in family planning. Despite this, Title X is facing the fight of a generation. In March, the administration published a final rule which, if enacted, would destroy the quality and integrity of Title X.

NFPRHA's opposition to this rule is well-documented and here are just some of our reasons why. The new rule undermines the Federal Government's own standard of care and opens the door to fund providers that will not offer a broad range of FDA-approved contraceptive methods. It eliminates the requirement that providers offer pregnancy options counseling at the patient's request, while requiring that all pregnant patients be referred for prenatal care, regardless of what the patient wishes. And it bars, absolutely, referrals for abortion, no matter the patient's wishes.

It requires that Title X-funded activities be physically separated from any non-Title X activity that touches on abortion and this would include health education and public health initiatives.

By limiting the services and the information available through Title X agencies, the rule undermines the trust and confidentiality that is so important when it comes to this most intimate and personal care.

If the rule is implemented, all Title X providers in every single location would be forced into only bad choices. They can withhold critical information and limit care to patients or they can leave the program and be less able or unable to care for low-income people in their community. This rule shows no respect and no regard for the millions of low-income people who today rely on Title X for their primary and often only healthcare.

Title X centers are located in 60 percent of U.S. counties but that is where 90 percent of women in need live. So these services are located where people need it and our services are intended to meet them where they live, focused on their needs and their values.

In addition to this rule, over the last decade, Title X has endured funding cuts that have led to more than a million people losing access to care and recent repeated funding announcements that have dismissed the expertise of so many longstanding providers. These attacks are wholly unwarranted and they are unjustifiable.

Title X has demonstrated, over 49 years, both quality and integrity. It is a true public health success story and it deserves strong bipartisan support.

I appreciate the opportunity to speak about the essential value that Title X plays in our nation's healthcare system.

Ms. DEGETTE. The lady's time has expired.

Ms. COLEMAN. I welcome any questions you have.

[The prepared statement of Ms. Coleman follows:]

National Family Planning & Reproductive Health Association

Written Testimony of Clare Coleman
President & CEO, National Family Planning & Reproductive Health Association

Before the Oversight and Investigations Subcommittee of the U.S. House of Representatives Committee on Energy and Commerce

Legislative Hearing on "Protecting Title X and Safeguarding Quality Family Planning Care"

June 19, 2019

Good morning.

Chairman Pallone, Chairwoman DeGette, Ranking Member Walden, Ranking Member Guthrie and members of the Subcommittee on Oversight and Investigations: thank you for the opportunity to testify before the subcommittee today. My name is Clare Coleman. For nearly ten years, I have served as the President & CEO of the National Family Planning & Reproductive Health Association (NFPRHA), the preeminent expert on and national advocacy organization for the Title X family planning program.

Founded the year after Title X's enactment, NFPRHA is a national, non-profit membership association that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially those in the safety net (i.e., those providing publicly funded care). NFPRHA envisions a nation where all people can access high-quality, client-centered, affordable, and comprehensive family planning and sexual and reproductive health care from providers of their choice. With respect to Title X, NFPRHA provides education, expert resources, and technical assistance to Title X-funded entities at grantee, subrecipient and service site level.

The association represents more than 850 health care organizations in all 50 states, the District of Columbia, and the US territories, and also includes in its membership individual professionals with ties to family planning care. NFPRHA's organizational members include state, county, and local health departments; private non-profit family planning organizations (including Planned Parenthood affiliates and many others); family planning councils; hospital-based health practices; and federally qualified health centers (FQHCs).

NFPRHA's members include Title X grantees in 48 states and two territories. And when grant sub-recipients (which in a few instances are subrecipients of sub-recipients) are considered, NFPRHA's membership includes at least one Title X grantee or one grant sub-recipient in every state.

NFPRHA currently has more than 65 Title X grantee members and almost 700 Title X sub-recipient members, which translates to NFPRHA representing more than 70% of Title X grantees and more than 90% of Title X service sites. These NFPRHA member organizations operate or fund a network of more than 3,500 health centers that provide family planning services to more than 3.7 million Title X patients each year.

Title X's History and Purpose

When Title X (ten) of the Public Health Service Act created the nation's only dedicated source of family planning in 1970, it included four major sections in the statute—services, training, research, and information—plus a prohibition on funds being used for abortion. Its creation reflected a bipartisan, broadly shared imperative to leverage medical advancements to address poverty and equity and improve health outcomes, especially for women in the United States.

During the 1960s, research showed that inequitable access to modern, effective contraceptives made low-income women less able to match their actual childbearing with their desired family size, which in turn affected their ability to get an education and earn a living, and also negatively affected their own health as well as the health of their children. At the time, the two most effective contraceptives—the then-new oral contraceptive pill ("the Pill") and the copper intrauterine device ("IUD")—were available only through medical professionals and at a high cost, both for the contraceptive itself and for medical visits.

President Richard Nixon therefore called on Congress to "establish as a national goal the provision of adequate family planning services … to all those who want them but cannot afford them," stressing that

"no American woman should be denied access to family planning assistance because of her economic condition.[1]" With an unanimous vote in the Senate and an overwhelmingly bipartisan 298 to 32 vote in the House, Congress enacted Title X in December 1970.

Congress's concern was the "medically indigent" – low-income individuals who desired but could not access the contraceptive methods that more affluent members of society could, and who were forced to do without, or to rely heavily on the least effective nonmedical techniques for birth control unless they happened to live in an area where family planning services were made readily available by public health agencies or voluntary organizations. Thus, Congress created Title X to provide low-income patients with equal access to biomedical contraceptives and related medical care, and to ensure those services would be voluntary, giving patients the true freedom to make their own decisions about whether and when to have children. Those purposes remain the Title X program's central focus nearly five decades later.

Congress amended the statute in 1975 to also explicitly permit Title X projects to include natural family planning (now sometimes known as fertility awareness) in the array of methods and services they offer to patients. Likewise, Title X was amended in 1978 to explicitly cover adolescent patients, who had been using Title X care from the start, and to include infertility services among those that Title X projects offer.

The Title X Program Today

Today, the Title X program helps more than four million people access family planning and related health services at nearly 4,000 health centers around the country annually.[2] Title X-funded health centers include a diverse array of providers, such as state and local health departments, freestanding family planning centers, Planned Parenthood affiliates, federally qualified health centers, hospitals, school- and university-based health centers, a diversity that allows patients to seek care at a site accessible to them. While Title X networks vary substantially because they are designed by communities for communities, Title X coverage across the nation, whether urban, rural, or suburban, is wide. In 2015, as Guttmacher Institute has reported, 60% of US counties had at least one health center supported by Title X, and 90% of women in need of publicly funded family planning care lived in those counties.

Title X has successfully served as a critical pathway to care for poor, low-income, uninsured, and under-insured individuals who may otherwise forego health care access. For many of these individuals, Title X-supported sites are their main access point to obtain affordable, confidential contraception care, cancer screenings, sexually transmitted disease testing and treatment, complete and medically accurate information about their sexual health and family planning options, and other basic care. In fact, a 2017 study found six in ten women seeking contraceptive services at a Title X health center saw no other health care providers that year[3]. In 2015 alone, for example, services provided by health centers that received Title X funding helped women avert an estimated 822,300 unintended pregnancies, thus preventing 387,200 unplanned births and 277,800 abortions.[4] Without the services provided by Title X–funded sites, the US unintended pregnancy rate would have been 31% higher.[5]

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[1] Richard Nixon, Special Message to the Congress on Problems of Population Growth (July 18, 1969)

[2] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[3] Mia Zolna, Megan Kavanaugh, and Kinsey Hasstedt. "Insurance-Related Practices at Title X-Funded Family Planning Centers under the Affordable Care Act: Survey and Interview Findings." Guttmacher Institute (November 2017). https://www.guttmacher.org/article/2017/11/insurance-related-practices-title-x-funded-family-planning-centers-under-affordable.

[4] Jennifer Frost et al. "Publicly Funded Contraceptive Services at U.S. Clinics, 2015." Guttmacher Institute (April 2017). https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015

[5] Jennifer Frost et al. "Publicly Funded Contraceptive Services at U.S. Clinics, 2015." Guttmacher Institute (April 2017). https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015

In addition to contraceptive counseling and supplies, and pregnancy testing and counseling, Title X providers also play a critical role in cervical and breast cancer screening and sexually transmitted disease and HIV services. Title X providers conducted, for example, more than 650,000 Pap tests in 2017; 14% percent of those tests identified results that required further evaluation and possible treatment related to cervical cancer. Providers also performed more than 900,000 chlamydia tests, 2.4 million gonorrhea tests, and 1.2 million HIV tests; more than 2,000 of the HIV tests were positive.[6]

Title X Appropriations

Despite this compelling data, and in spite of the critical importance of equitable access to family planning services for all people, Title X has consistently been underfunded. The program has been appropriated at just over $286 million for the past six fiscal years. In 2016, researchers from the Centers for Disease Control and Prevention, the Office of Population Affairs, and George Washington University estimated that Title X would need $737 million annually to deliver family planning care to all uninsured, low-income women in the United States.[7] This estimate understates the true need for Title X, as it does not include an estimate of costs for men (who made up 12% of patients in the network in 2017[8]), does not account for Title X's trans and nonbinary patients, and does not include an estimate for insured patients who rely on Title X's confidentiality protections.

The gap between the funds appropriated and the funds needed has only grown in recent years. From 2010 to 2014 the number of women who needed publicly funded family planning services increased by one million[9] and the cost of providing services and maintaining sites increased, but Congress cut Title X's funding by $31 million over that period. That decrease unfortunately corresponds to dramatic decreases in the number of patients served at Title X-funded sites; the numbers dropped from 5.22 million in 2010[10] to just over four million in 2017.[11]

In April 2019, the House Appropriations Committee recognized these challenges and adopted NFPRHA's recommendations to strengthen the Title X program by including an appropriation of $400 million. The fiscal year (FY) 2020 appropriations bill for the Departments of Labor, Health and Human Services, and Education remains pending.

Title X is a Unique and Essential Safety-Net Resource that Attracts Highly Qualified Providers

Of the $286.5 million that has been annually appropriated to the program in recent years, approximately $260 million supports family planning service delivery. Each Title X project supplements its federal funding with service reimbursement payments, such as from Medicaid or private insurance, patient-paid fees—from those with incomes between 101% and 250% of the annual federal poverty level (FPL) who are thus eligible for Title X's sliding fee scale, instead of no-cost care (as Title X ensures for those with

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[6] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[7] Euna August, et al, "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health* (February 2016): 334-341.

[8] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[9] Jennifer Frost, Lori Frohwirth and Mia Zolna, "Contraceptive Needs and Services, 2014 Update," Guttmacher Institute (September 2016). https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

[10] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[11] Fowler et al, "Family Planning Annual Report: 2016 National Summary."

incomes below the FPL), as well as from patients paying full fee for their care—and/or state, local or private sources.

To be clear, while the federal Title X grants may not serve as the largest source of revenue to support a family planning project, they are the essential backbone of this national program. All care within any Title X project, even though the Title X grant is only a part of the project's budget, is bound by the federal law, regulations, and clinical and administrative standards of the Title X program. Specifically, Title X requires the critical feature of no-cost care for low-income patients, supports staff and infrastructure expenses that are not reimbursable under insurance, arises out of merit-based selection of grantees, and requires providers to comply with all of the Title X program's comprehensive requirements.

As a result, Title X-funded family planning organizations typically have deep expertise in the care they provide and the federally regulated framework in which they provide it. And they are highly responsive to patient concerns and needs. Many current grantees and sub-recipients have been part of the Title X network for decades. A number have been part of Title X care from the very beginning of the program. The experience and intense dedication of current Title X providers to their patients' family planning and sexual health is reflected in the quality of care they deliver.

Title X providers are Title X family planning providers, for example, typically offer a greater number of contraceptive method options to their patients than do non-Title X health care providers and are more likely to offer those options onsite rather than requiring a patient to go to a pharmacy or to another provider for insertion of an IUD or implant.[12] And Title X providers spend more time with patients during an initial contraceptive visit and other counseling than do clinicians at non-Title X sites.[13]

Equally important, Title X providers strive to create a welcoming, non-judgmental atmosphere and openness to Title X patients' own stated needs, and respect each individual patient's values and autonomy. That kind of respectful and professional atmosphere allows providers to build and maintain trust, whether with a new patient or a returning one. This has been as important to Title X's longtime effectiveness as the scope and expertise of its clinical care.

Title X is the Gold Standard for Quality Family Planning Care
Because Title X aims to provide poor and low-income patients equal access to quality, up-to-date family planning methods and services, HHS has periodically adopted and revised clinical standards and other program guidance toward that end. These HHS directives govern grantees and their provider networks to help ensure that Title X programs are offering evidence-based clinical care consistent with current nationally recognized standards.

In 2009, in a memorandum distributed to Title X grantees, OPA acknowledged that its directives had in some respects fallen behind then-currently recognized clinical standards; subsequently, the agency initiated an extensive updating process. The process culminated in April 2014 with the publication of two documents that currently comprise OPA's main Title X program guidance: (1) OPA's Title X Program Requirements; and (2) the *Quality Family Planning* guidelines (QFP) – the joint CDC and OPA publication on clinical standards for providing quality family planning services, as updated periodically. The CDC has since published updates on additional research related to the QFP, including as recently as

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[12] Kinsey Hasstedt. "Why We Cannot Afford to Undercut the Title X National Family Planning Program." *Guttmacher Policy Review* 20 (2017). https://www.guttmacher.org/sites/default/files/article_files/gpr2002017.pdf

[13] Kinsey Hasstedt. "Why We Cannot Afford to Undercut the Title X National Family Planning Program." *Guttmacher Policy Review* 20 (2017). https://www.guttmacher.org/sites/default/files/article_files/gpr2002017.pdf

December 2017, which have continued to reinforce the validity of the QFP standards. OPA has explicitly incorporated the QFP into its current requirements for and monitoring of all Title X projects.

The QFP describes clinical standards for any family planning provider, whether funded by Title X or not, and incorporates other national standards such as the CDC preconception care and STD treatment guidelines and the US Medical Eligibility Criteria for Contraceptive Use. The QFP was the result of a lengthy process involving dozens of technical experts and the Expert Working Group of which I was a part. It drew on the CDC's "longstanding history of developing evidence-based recommendations for clinical care" and the fact that "OPA's Title X Family Planning Program has served as the national leader in direct family planning service delivery" since 1970.

The QFP's recommendations "outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services."[14] The QFP standard is to provide equitable, evidence-based care consistent with current professional knowledge, so that family planning does not vary in quality because of the personal characteristics of clients.

The Trump Administration Has Sought to Undermine Title X's Program Integrity

Unfortunately, as partisanship has intensified in Washington and family planning has been politicized, Title X has become a target. The current administration has sought to reshape the Title X network and divert its essential resources away from the core purposes of the program.

In the 2018 funding opportunity announcement (FOA) that outlines how applicants can apply for service delivery grants, for example, HHS sought to require grantees to emphasize education and counseling programs that would encourage "sexual risk avoidance" i.e., abstinence—or "returning to a sexually risk-free status" for unmarried patients, including adults.[15] The FOA also sought to impose a "meaningful emphasis" on abstinence[16], even though the clear, motivating purpose behind Title X was to help sexually active individuals manage their fertility through modern contraception, and more than 95% of adult Title X patients are or wish to be sexually active.

Strikingly, nowhere in the 60-page 2018 FOA appeared the words contraceptive or contraception.[17] Similarly, the 2018 FOA nowhere mentioned the QFP or required compliance with these standards of care. The 2018 FOA also failed to draw upon OPA's own Program Requirements and Policy Notices, or otherwise required prospective grantees to comply with them. Instead, the 2018 FOA encouraged applications for projects that use methods that are "historically underrepresented in the Title X program." Because Title X providers have been in the forefront of offering all methods of family planning, including the most effective and up-to-date ones, for ultimate choice by patients, this preference for "underrepresented" methods represented a step backward from current clinical standards and data documenting which methods are most acceptable to patients.

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[14] Loretta Gavin et a. "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." *Morbidity and Mortality Weekly Report* 63.4 (April 25, 2014).

[15] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

[16] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

[17] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

For example, the FOA repeatedly reiterated the need for Title X projects to include natural family planning methods, which are offered by Title X providers but are one of the least effective methods (according to HHS) and chosen by less than 0.5% of users. Thus, despite the fact that Title X's longstanding regulations require projects to offer a broad range of "acceptable and effective medically approved family planning methods and services," the 2018 FOA named only natural family planning, one of the least effective and acceptable methods (as demonstrated by its low demand), and ignored the regulations' specific requirements that Title X projects, for example, "provide for the effective use of contraceptive devices and practices" by their patients.
The 2018 FOA also sought to give priority to providers interested in "a holistic vision of health" in the Title X program.[18] These were code words for bringing certain providers' values—against sex outside marriage and against abortion—into Title X and efforts to direct grants to those providers. When HHS did not get the number and kind of grant applications from such providers in the FY 2018 grant competition that it sought, it imposed a very short grant period (seven months as opposed to the usual three years) to trigger another competition of the entire national network. It also moved to publish current grantees' in-depth and proprietary applications on the HHS website to give potential new entrants material to assist in their application efforts. Both the 2018 FOA and the HHS efforts to publicly post current grantees' applications resulted in litigation.

On March 4, 2019, the administration finalized the Title X rule "Compliance With Statutory Program Integrity Requirements," in the *Federal Register*. The rule builds on previous efforts by the Trump administration to divert Title X funds, direct them toward uses that are not properly part of the Title X program, and remove this federal funding from any entities that also provide abortions outside Title X.

There has only been one previous attempt by the executive branch to remake the program from one intended to ensure equal access to quality clinical family planning services so that poor and low-income individuals can freely determine their own childbearing, into a coercive ideological program that imposes choices and limits information when Title X patients find themselves pregnant. At the end of the Reagan administration in 1988, HHS promulgated a rule with similarities to the one issued by the Trump administration this year, though it was not nearly as expansive. Those 1988 rules were enjoined immediately, remained blocked through years of litigation and were ultimately rescinded in January 1993.

Under the new rule, HHS seeks to prioritize the beliefs and values of hypothesized, potential Title X providers over the needs and wishes of the patients who might seek care at sites operated by them. Specifically, the rule would allow potential new Title X providers to use their religious beliefs to limit the methods of family planning they might offer to patients within the Title X program, without informing patients or ensuring that they can access the care appropriate for them elsewhere.

The new rule also subverts the voluntariness and patient-centeredness that is central to Title X care, and would leave poor and low-income patients inadequate, second-class care. In so doing, the new rule fundamentally undermines universal access for low-income patients to the national standard of care to which the Title X program is now held.

The rule forces a Hobson's Choice, each of which harm patients as well as the providers: it forces all current, effective providers to either (1) attempt to stay in the Title X program out of a commitment to low-income individuals' access to family planning care, despite the compromised care newly mandated

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[18] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

by the rule, or (2) leave Title X because the rule requires providers to depart from standards of care and medical ethics principles -- thereby shrinking the Title X network, reducing patients' access to family planning and related care, and triggering cascading harms.

If implemented, the final rule would damage the nation's family planning program and severely diminish, rather than increase, the public health benefits realized from the limited funding available to the program. It would have far-reaching implications for all Title X-funded entities, the services they provide, and the ability of patients to receive the confidential family planning and related sexual health care they seek. NFPRHA is actively engaged in litigation to prevent this rule from taking effect, and the rule is currently enjoined by the courts.

Aspiring to a Better Outcome

While the Title X network struggles with stagnant resources and under seemingly endless attack, our country and this Congress are missing critical opportunities to improve outcomes related to sexual and reproductive health and advance needed health reforms. I'm grateful that this hearing today gives me a chance to raise just one idea.

When Title X was envisioned and created nearly a half a century ago, it was meant to reduce inequity. It did so in part by requiring that services be offered for free to people with incomes under 100% FPL and on a schedule of discounts, or sliding fee scale, to those with incomes between 101-250% FPL (roughly $12,500 to $31,225 a person). Today, because the health care landscape has evolved, that cost-sharing approach is now contributing to inequity.

Since 2014, more and more Americans have gained access to private insurance, through which contraceptive coverage is offered at no cost-sharing, and it has long been the case that those who access health care through Medicaid have family planning as a required service with no cost-sharing. That leaves a troubling, unjustifiable gap: uninsured, low-income people with incomes between roughly $12,500 and $31,225 are expected to share the costs of their family planning and sexual health care in a way that other populations are no longer required to do.

Addressing that cost gap would be an essential element of our nation's next health reforms, and perhaps it would lead the way to other needed improvements in our system of care, especially for those with the least among us. To do right by all Americans, we should ensure that different types of insurance, which often correlates with income, do not mean different breadth and depth of health care. This is especially important when it comes to family planning and sexual health, which is deeply sensitive and involves the most intimate aspects of our lives.

If we could expend less energy trying to maintain the integrity of the public health success story that is Title X, we could together align using a public health lens: work to advance more access points, equity across the board, and high-quality care across all provider settings. Only then can we fulfill President Nixon's vision for the "provision of adequate family planning services … to all those who want them but cannot afford them."

Conclusion

In conclusion, thank you for this opportunity to offer testimony on the unique value of our nation's family planning program, and I welcome continued dialogue on Title X and ways to bolster the family planning safety net nationwide. I am happy to answer any questions that you may have.

Ms. DEGETTE. The Chair now recognizes Ms. Geoffray for five minutes.

STATEMENT OF KAMI GEOFFRAY

Ms. GEOFFRAY. Chairwoman DeGette, Ranking Member Guthrie, and members of the subcommittee, thank you for holding this hearing and inviting me to testify today.

As Chief Executive Officer of the Women's Health and Family Planning Association of Texas, I oversee the administration of the second largest Title X Family Planning Services grant award in the nation. I am here today to tell you about the serious challenges faced by the family planning safety-net providers in my State and the clients they serve, and to share my concerns that, if implemented, the changes the current administration seeks to impose on the Title X Family Planning program will reduce access to critical reproductive health services in communities across the country, mirroring what we experienced in Texas in recent years.

I also am here to tell you about the role Title X grantees and sub-recipients play in providing high-quality family planning services that are informed by the unique needs of each community and delivered with respect and dignity for each individual.

The Texas experience serves as a cautionary tale of the deeply harmful consequences that can result when policymakers target particular family planning providers. In 2011, State lawmakers made a series of funding and policy decisions that ultimately resulted in 82 family planning clinics, one out of every four in our State, closing or reducing hours, restricting access to critical reproductive health services across the State. The intended target was family planning providers that also provide abortion services or affiliate with abortion service providers; but the consequences reached much further. Two-thirds of the clinics impacted were family planning providers that had no affiliation with abortion service providers and tens of thousands of Texans lost access to services.

The impact was quickly observed. Contraceptive use decreased, while the rates of unintended pregnancies and abortions increased. Overall, the Texas experience teaches us that once lost, access to critical reproductive health services is difficult or impossible to reestablish. Over the last eight years, significant funding has been invested to bolster a family planning safety-net that was weakened by a series of the Texas legislature's decisions. Yet, it appears that State-funded programs still are not serving as many individuals today as they did in 2011.

The Title X rule finalized by the current administration seeks to implement several of the misguided policies piloted in Texas, forcing family planning providers that also provide abortion services from the program, and prioritizing primary care providers over those focused on reproductive healthcare. If implemented, these policy proposals will reduce access to family planning services and likely result in similarly negative outcomes as those seen in Texas in recent years.

Finally, I would like to speak about the qualified providers of high-quality family planning services that make up the Title X grantee and sub-recipient network.

We develop healthcare networks that are informed by our communities that we serve and that are as diverse as the geography and demographics of the States in which we work. We work diligently to ensure that the Federal dollars that we have been entrusted with administering are used to support evidence-based, client-centered family planning care of the highest quality. We implement detailed systems to ensure compliance with program statutes, regulations, and legislative mandates at the grantee and sub-recipient levels. Collectively, we provide critical reproductive health services and a full range of contraceptive methods to four million individuals each year but we have the capacity to do so much more if additional funding were made available.

In closing, I urge you to learn from Texas and ensure that Title X funding continues to be administered by those most qualified and committed to providing a full package of family planning services in an evidence-based, client-centered manner, helping to advance the reproductive health and well-being of millions of low-income, uninsured, and underinsured individuals who turn to Title X for care every year.

Thank you for the opportunity to testify today. I look forward to answering any questions you may have.

[The prepared statement of Ms. Geoffray follows:]

WOMEN'S HEALTH
AND FAMILY PLANNING
ASSOCIATION OF TEXAS
[whfpt.org]

STATEMENT OF

KAMI GEOFFRAY
CHIEF EXECUTIVE OFFICER
WOMEN'S HEALTH AND FAMILY PLANNING
ASSOCIATION OF TEXAS

FOR A HEARING ON

PROTECTING TITLE X AND SAFEGUARDING QUALITY FAMILY PLANNING CARE

BEFORE

HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JUNE 19, 2019

Chairman Pallone, Chairwoman DeGette, Ranking Member Walden, Ranking Member Guthrie and members of the Subcommittee –

Thank you for holding this hearing and inviting me to testify. My name is Kami Geoffray and I am the Chief Executive Officer of the Women's Health and Family Planning Association of Texas, where I oversee the administration of the second-largest Title X family planning services grant award in the nation. We are proud to have served as the statewide Title X grantee for Texas since 2013 and to be an active member of the National Family Planning and Reproductive Health Association, also represented on the panel today. I am honored to testify today on behalf of our 37 Title X sub-recipient agencies operating more than 140 service sites across Texas, as well as on behalf of the nearly 200,000 women, men, and adolescents we serve each year with Title X funding.

I have been working to advance people's access to reproductive health care in Texas since 2012. I am here today to tell you about the serious challenges faced by the family planning safety net providers in my state and the clients they serve, and to share my concerns that, if implemented, the changes the current administration seeks to impose on the Title X family planning program will reduce people's access to critical reproductive health services in communities across the country, mirroring what we experienced in Texas in recent years. I also am here to tell you about the role Title X grantees and sub-recipients play in providing client-centered, high-quality family planning services to over 4 million individuals each year—services informed by the unique needs of each community and delivered with respect and dignity for each individual.

The Texas experience serves as a cautionary tale of the deeply harmful consequences that can result when policymakers target particular safety net family planning providers. During the 2011 legislative session, state lawmakers made a series of funding and policy decisions that ultimately resulted in 82 family planning clinics (one out of every four in the state) closing or reducing hours, restricting access to critical reproductive health services across the state.[1] The intended target was safety net family planning providers that also provide abortion services or affiliate with abortion service providers—Planned Parenthood affiliates specifically. These providers were indeed blocked from participating in the family planning programs administered by the state. And the consequences reached much further: two-thirds of the clinics impacted were family planning providers that had no affiliation with abortion service providers,[2] and tens of thousands of Texans lost access to services. Coupled with the loss of the state's Medicaid family planning waiver, all state-funded family planning programs experienced a dramatic decline in the

[1] Kari White, Kristine Hopkins, Abigail Aiken, Amanda Stevenson, Celia Hubert, Daniel Grossman, and Joseph E. Potter, *The impact of reproductive health legislation on family planning clinic services in Texas*, American Journal of Public Health 105(5):851-858 (2015) (finding that after the family planning budget was cut from $111 million to $38 million, 82 Texas family planning clinics closed or stopped providing family planning services). *See also* Joseph E. Potter and Kari White, *Defunding Planned Parenthood was a disaster in Texas. Congress shouldn't do it nationally*, Washington Post, February 7, 2017, https://www.washingtonpost.com/posteverything/wp/2017/02/07/defunding-planned-parenthood-was-a-disaster-in-texas-congress-shouldnt-do-it-nationally.

[2] White, et. al. (2015), *supra* note 1 (finding that following 2011 cuts two-thirds of the clinics that closed were not Planned Parenthood clinics).

number of clients served,[3] and the further impact of reduced access to reproductive health services was quickly observed: contraceptive use decreased while the rates of unintended pregnancies and abortions increased.[4]

Faced with the considerable consequences to individuals and public health, Texas lawmakers created a new program during the 2013 legislative session—the Expanded Primary Health Care Program—that sought to integrate family planning and primary care. The Texas Legislature invested $100 million in this program, technically restoring funding to pre-2011 levels. A study of the effectiveness of the program concluded that many primary care organizations in Texas lacked the capacity to provide the kind of evidence-based family planning services that women's health organizations had been providing for decades.[5] The study also found that clinicians in primary care organizations often lacked training to provide long-acting reversible contraceptive (LARC) methods, and reported employing contraceptive protocols that were not evidence-based.[6] Moreover, despite this new program, the number of clients served in the state-funded family planning programs did not rebound to previous levels.

Texas lawmakers once again increased their investment in family planning programs in 2015, appropriating an additional $50 million.[7] By 2017, the number of clients served had finally started trending in the right direction—in part due to substantial new investments to increase enrollment and in part due to an increase in participation by family planning providers focused on reproductive health care (although providers that also provided abortion services or affiliated with abortion service providers continued to be excluded, as well as providers that objected to signing the required attestation). Yet, despite substantial new funding and efforts to boost enrollment, it appears that state-funded programs still were not serving as many women in 2018 as they did in 2011[8]—even though Texas experienced significant population growth during the

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[3] *Id.* (finding that following 2011 cuts 54% fewer clients were served).

[4] Joseph Potter & Kari White, *Health Cuts by Legislature Have Made Texas Childbirth Riskier*, Waco Tribune Herald (August 30, 2016), http://www.wacotrib.com/opinion/columns/guest_columns/joseph-e-potter-kari-white-texas-perspectives-health-cuts-by/article_53277ccc-5f33-5f80-9100-c7c8e7ed37f1.html. *See also* C. Woo, H. Alamgir, & J. Potter, *Women's experiences after Planned Parenthood's exclusion from a family planning program in Texas*, Contraception, 93(4), 298-302 (2016) (concluding that injectable contraception use was disrupted as a result of changes to the state-funded family planning program) and A.Stevenson, I. Flores-Vazquez, R. Allgeyer, P. Schenkkan, & J. Potter, *Effect of removal of Planned Parenthood from the Texas Women's Health Program*, New England Journal of Medicine, 374(9), 853-860 (2016) (concluding that the exclusion of Planned Parenthood affiliates from a state-funded replacement for a Medicaid fee-for service program in Texas was associated with adverse changes in the provision of contraception, a reduction in the rate of contraceptive continuation, and an increase in the rate of childbirth covered by Medicaid).

[5] Kari White, Kristine Hopkins, Daniel Grossman, and Joseph E. Potter, *Providing family planning services at primary care organizations after the exclusion of Planned Parenthood from publicly funded programs in Texas: Early qualitative evidence*, Health Services Research 53(4, Part II): 2770-2786 (2018).

[6] *Id.*

[7] Legislative Budget Board, *Women's Health Funding Infographic* (September 2016), https://www.lbb.state.tx.us/Documents/Publications/Info_Graphic/3040_Womens_Health_Funding.pdf.

[8] Stacey Pogue, *Good and Bad News on Family Planning in New Health and Human Services Report*, Center for Public Policy Priorities CPPP Blog (April 27, 2018), http://bettertexasblog.org/2018/04/good-and-bad-news-on-family-planning-in-new-health-and-human-services-report/. *See also* Texas Health and Human Services Commission, *Texas Women's Health Programs Report Fiscal Year 2018* (May 2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/tx-womens-health-fy2018-annual-report-may-2019.pdf

same period.[9] Of course, this is about more than just data. Every Texan who lost access to critical reproductive health services during this tumultuous time was impacted in ways that we will never be able to measure at the population level and that have the potential to change the trajectory of a person's life. The stories of people no longer able to access wanted, needed reproductive health care are not often told in reports or studies,[10] but I urge you to remember that each funding and policy decision you make impacts a very real person who relies on the publicly funded programs you are charged with appropriating and legislating.

Overall, the Texas experience teaches us that, once lost, access to critical reproductive health services is difficult or impossible to reestablish. Over four legislative sessions, as documented in the chart below (showing spending on women's health programs for fiscal years 2006 through 2021),[11] Texas invested significant amounts of general revenue funding to bolster a family planning safety net that was weakened by a series of the Texas Legislature's decisions: to cut the state's family planning program funding by two-thirds, tier remaining funding, and distribute funds to those providers less likely to see high volumes of family planning clients. Today, nearly a decade later, the number of clients served annually in the state-funded family planning programs appears to be lower than the number served in 2011—despite subsequent reinvestments. In essence, the Texas Legislature gutted its family planning infrastructure, and found that increasing funding could not make up for the loss of so many qualified family planning providers. Meanwhile, years of progress and institutional knowledgeable were lost and may never be regained. In the state with the highest rate of uninsured individuals[12] and with 1.8 million women in need of publicly funded contraception,[13] it is nothing short of tragic to eliminate access to critical reproductive health care through the enactment of misguided policies.

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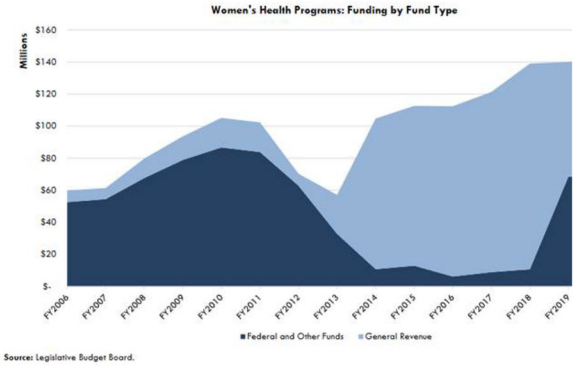
[9] Derick Moore, *Texas Added the Most People but California Still Most Populous*, America Counts: Stories Behind the Numbers, (January 16, 2018), https://www.census.gov/library/stories/2018/01/state-pop-tableau.html (reporting Texas had the most growth with 3,555,731 people added, a 14.1% increase, from April 1, 2010 to July 1, 2018).
[10] Kristine Hopkins Kristine, Kari White, Fran Linkin, Celia Hubert, Daniel Grossman, and Joseph E. Potter, *Women's experiences seeking publicly funded family planning services in Texas*, Perspectives on Sexual and Reproductive Health 47(2):63-70 (2015) (finding that although most women who participated in focus groups conducted a year after legislation that reduced access to family planning services was enacted were not aware of legislative changes, they reported that in the past year they had had to pay more for previously free or low-cost services, use less eff ective contraceptive methods or forgo care).
[11] Legislative Budget Board, Health and Human Services Commission Summary of Recommendations – Senate (January 2019), http://www.lbb.state.tx.us/Documents/SFC_Summary_Recs/86R/Agency_529.pdf.
[12] Matthew Buettgens, Linda J. Blumberg, and Clare Pan, *The Uninsured in Texas: Statewide and Local Area Views*, Urban Institute (December 2018), https://www.episcopalhealth.org/files/2715/4447/0560/201812.10_Uninsured_in_Texas_FINAL.pdf (estimating that 19% of Texas residents lack health insurance coverage, which is nearly twice the national average).
[13] JJ Frost et al., *Contraceptive Needs and Services, 2014 Update*, Guttmacher Institute (2016), https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.



If the Women's Health and Family Planning Association of Texas had not been granted the statewide administration of the Title X grant in 2013, I fear that the impacts to the family planning safety net would have been even greater. Title X funding, as administered by our organization, assisted Title X sub-recipients in reestablishing access points and in increasing the number of clients served. Our organization was able to restore Title X funding to approximately half of the 23 organizations that lost funding in 2011, but other organizations no longer existed or had stopped providing family planning services. If the current administration adopts policies similar to those piloted in Texas within the Title X family planning program, I am concerned that the Texas family planning safety net may not survive further destabilization.

Additionally, I am worried for my colleagues across the nation that they, too, may experience what we have in Texas. The Title X rule finalized by the current administration seeks to implement several of the misguided policies piloted in Texas: forcing family planning providers that also provide abortion services from the program and prioritizing primary care providers over those focused on reproductive health care. If implemented, these policy proposals will reduce access to family planning services and likely result in similarly negative outcomes as those seen in Texas in recent years.

I fear that the most qualified Title X providers will end their participation in the program because of overly burdensome requirements, government interference with the patient/provider relationship, and the enforcement of policies that are not evidence-based. In Texas, many providers that are qualified to participate in state-funded family planning programs choose not to do so because they object to the state's requirement that all providers attest that they do not perform or promote elective abortions, or affiliate with providers who perform or promote elective abortions. Others object to the state's decision to exclude emergency contraception from its list of covered contraceptive methods. Should this administration be allowed to undermine evidence-based and client-centered services and interfere with the patient/provider relationship in the Title X family planning program, our experience in Texas shows that we risk the loss of qualified providers and, in turn, reduced access to high-quality family planning services in communities across the country.

In closing, I would like to speak a bit about the qualified providers of high-quality family planning services that make up the Title X grantee and sub-recipient network. We develop health care networks that are informed by the communities we serve, and that are as diverse as the geography and demographics of the states in which we work. We work diligently to ensure that the federal dollars that we have been entrusted with administering are used to support evidence-based, client-centered family planning care of the highest quality—informed by the Quality Family Planning recommendations jointly developed by the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA) and first published in 2014.[14] We implement detailed systems to ensure compliance with program statutes, regulations, and legislative mandates at the grantee and sub-recipient levels. We support family planning safety net providers who often do not have the financial or human resources to navigate the constantly changing funding and policy realities that exist at the federal, state, and local levels. Collectively, we provide critical reproductive health services and a full range of contraceptive methods to 4 million individuals each year—but have the capacity to do so much more if additional funding were made available.

Our organization and our network of sub-recipients are committed to administering Title X funding in Texas with the highest integrity. This is proven not only by our efforts to rebuild, and in some places even to expand, the infrastructure that Texas lawmakers worked so hard to dismantle, but also by the quality and effectiveness of the services our sub-recipients deliver to their communities. Recent studies of the Texas family planning safety net found that client-centered, non-directive pregnancy options counseling was more common among Title X sub-recipients than state-only funded organizations[15] and that Title X sub-recipients were less likely to report practices and barriers preventing women from receiving their preferred contraceptive method in a timely manner than state-only funded organizations.[16] While the funding we provide is critical to the success of our sub-recipients, so are the exacting quality assurance and monitoring activities and the training and technical assistance on best practices that we offer.

Given the opportunity to sit at this table today, other grantees and sub-recipients could describe to you the innovative ways in which they too are meeting the unique needs of the communities they serve—from employing the use of telemedicine and mobile units to deliver family planning services outside the four walls of a clinic, to partnering with community-based organizations to conduct culturally appropriate outreach and education about the availability of Title X services, to providing mental health and substance use disorder screening in the context of family planning services, to maintaining robust referral networks for a host of health care and social services to ensure that each client's individual needs are met. Each Title X project is designed by

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[14] Loretta Gavin, Susan Moskosky, Marion Carter, et al., *Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs*, MMWR Recomm Rep 2014;63(No. RR-04).
[15] Kari White, Katelin Adams, and Kristine Hopkins, *Counseling and referrals for women with unplanned pregnancies at publicly funded family planning organizations in Texas*, Contraception 99(1) 48-51 (2019).
[16] Kari White, Elizabeth Ela, Kristine Hopkins, and Joseph E. Potter, *Providers' Barriers to Offering Contraception in the Healthy Texas Women (HTW) Program*, Texas Policy Evaluation Project Research Brief (2019), https://liberalarts.utexas.edu/txpep/research-briefs/htw-provider-evaluation-brief.php.

communities, for communities, informed by the key tenant of Title X: to provide poor and low-income patients equal access to quality family planning services

As I have shared with you today, I believe that, if implemented, the administration's dramatic changes to the Title X family planning program would undermine the integrity of the nation's family planning safety net in ways similar to what we experienced in Texas. Instead, we should learn from Texas and ensure that Title X funding continues to be administered by those most qualified and committed to providing a full package of family planning services in an evidence-based, client-centered manner, helping to advance the reproductive health and well-being of millions of low-income, uninsured, and underinsured individuals who turn to Title X for care every year.

Thank you for the opportunity to testify today. I look forward to answering any questions you may have.

Ms. DEGETTE. Thank you so much.

The Chair now recognizes Dr. McLemore for five minutes for purposes of an opening statement.

STATEMENT OF MONICA MCLEMORE, PH.D.

Dr. MCLEMORE. Chair DeGette, ranking members, and the entire committee, I really appreciate you providing me an opportunity to be able to provide my expertise for you and with you. It has been interesting we have been hearing about scientific experts and it is kind of ironic that I am the first one to speak.

I am grateful to provide clinical, scientific, and research expertise to the committee. I have been a licensed registered nurse since 1993 and for most of my career, I worked clinically in facilities that receive Title X funding. Since 2002, I have worked clinically at Zuckerberg San Francisco General Hospital and Trauma Center, a place with co-located services.

I am an expert nurse in the provision of sexual and reproductive health services. I sit before you as the incoming chair for Sexual and Reproductive Health for the American Public Health Association.

Ensuring all people of reproductive age can achieve their reproductive life goals is an essential component of reproductive health and public health. Additionally, reproductive justice is essential to bodily autonomy, human rights principles, and existential liberation for all humans. Simply put, reproductive justice posits that every person has the right to decide if, when, and how to become pregnant, and to determine the conditions under which they will birth and create families.

Next, every person has the right to decide that they will not become pregnant, and have all options for preventing and/or ending pregnancies, and have those means be accessible and available.

Third, individuals have the right to parent their children they already have with dignity and without fear of violence from individuals of the Government.

And finally, individuals have the right to disassociate sex from reproduction and that health, healthy sexuality, and pleasure are essential components to a whole and full human life.

Academicians, activists, clinicians, researchers, and scholars like me believe that Title X and Title V are essential components to achieving reproductive justice. There are currently 4,000 entities designated as Title X grantees and 40 percent are Planned Parenthood health facilities. I wanted to correct that incorrection from earlier. Half the people served at Title X clinics are people of color.

I also want to correct the record that nurses, nurse practitioners, nurse midwives, and public health nurses have been the mainstay of the sexual reproductive healthcare workforce, including in Title X and Planned Parenthood centers and we provide a crucial access for vulnerable and low-income populations. These clinics also provide essential training for nursing and medical students and potential clinic closures can reduce the pipeline of appropriately trained clinicians.

The proposed rule change violates the American Nurses Association Code of Ethics that reads, and I quote, "the ANA has historically advocated for the healthcare needs of all patients, including

services related to reproductive health. The American Nurses Association also believes that healthcare clients have the right to privacy and the right to make decisions about personal healthcare based on full information and without coercion."

As a nurse scientist, this work is personal for me. Let me tell you how Title X has helped me earn three degrees from public institutions, and become a visible scholar and thought leader on black maternal health. I am a member of the populations most served by Title X. As a poor post-doc in 2011, I almost bled out in my car, due to fibroids, driving into San Francisco to see my mentor. My sister, my mom, and like many black Americans, fibroids is a huge problem. And I was able to receive a Mirena IUD at a Title 10 clinic that I still have to this day.

This allowed me to complete my studies, to generate and publish 48 papers, including 17 op-eds, two of which were about the protection of Title X. And in those publications, I also was able to optimize information to the public during Black Maternal Health Awareness Week, sponsored by the Black Mamas Matter Alliance.

I have been able to provide clinical care to the public, which I still do, and am soon to becoming the incoming chair for Sexual and Reproductive Health at the American Public Health Association.

In November, I will be fortunate enough to be inducted as a fellow of the American Academy of Nursing, who also signed on against this rule change. And I am still waiting to hear if I will become the fifth tenured black person in a 113-year history of the University of California San Francisco School of Nursing.

Achieving my reproductive goals has allowed me to become the scholar, and the reproductive justice has been operationalized in my life, and all the people served by Title X clinics and providers deserve the same opportunity.

Thank you.

[The prepared statement of Dr. McLemore follows:]

2019 Comments on behalf of Monica R. McLemore PhD, MPH, RN
16 June 2019

Academic Credential for Identification Purposes Only:
Assistant Professor, Family Health Care Nursing Department
Clinician-Scientist, Advancing New Standards in Reproductive Health (ANSIRH)
Member, Bixby Center for Global Reproductive Health
University of California, San Francisco

Speaking Perspective:
Incoming Chair, Sexual and Reproductive Health Section of the American Public Health Association, 2018-2024

Advisory Committee Member for the Black Mamas Matter Alliance, 2018-2020

Prepared for:
116th Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 Rayburn House Office Building

I am grateful to provide my clinical, scientific, and research expertise to the committee in written form to educate the committee about the importance of Title X, the federal family planning program, that serves low-income individuals – that was signed into law in 1970, by then President Richard Nixon. It is important to recognize that I have published evidence-based OpEds specific to this issue[1-2] and I include these writings as an official component of my written testimony. I will cite my work and the work of others to provide primary sources for the data I use in this testimony.

Positionality and Expertise

I have been a licensed registered nurse since 1993 and for most of my career I have worked clinically in facilities that have received Title X funding. This includes 18 years with my current clinical employer, Zuckerberg San Francisco General Hospital and Trauma Center; an additional combined 9 years at Planned Parenthood, Kaiser Permanente, and Stanford University Medical Center. I am an expert nurse in the provision of sexual and reproductive healthcare services. My skills include patient education and counseling, provision of contraception and abortion services, ultrasound, cardiac monitoring, procedural sedation, symptom management, telephone triage, and emotional and physical support. As a faculty member, I teach in courses such as Childbearing Families, Maternal Child Nursing, and Contraception in Primary Care – a pharmacology course for advanced practice clinicians. As a researcher I explore topics within sexual and reproductive healthcare provision, specific but not exclusive to nurses and patients' experiences of their care. I employ reproductive justice (RJ) as a theory and praxis to guide all of my work – a full definition of RJ is provided with other definitions I use throughout this written testimony.

Outline of Testimony

I have planned my oral testimony around three distinct themes and my written testimony mirrors that approach. These four categories are: 1) Impact on Public Health Goals, and more specifically why the proposed rule change is a direct violation of principles of reproductive justice; 2) The Professional and Ethical Responsibilities of Providers and the Confidentiality and Privacy Issue Caused by the Rule Change; and finally, 3) How the Rule Change Stymies Innovation & Increases Healthcare Costs. First, I plan to define terminology; next I present these themes; finally, I end with some resources that I believe are crucial to fully understand the potential impact of this rule change and to increase the knowledge of those involved in this investigation.

Definitions

- Where appropriate, I used gender neutral language to encompass the widest range of the public that we serve. People with the capacity for pregnancy is the preferred term I use for people who birth other humans.
- Reproductive Justice (RJ) is is simultaneously a theory, practice and a strategy that is grounded in four principles. Simply put, RJ posits that every person has the right to decide if and when to become pregnant and to determine the conditions under which they will birth and create families. Next, every person has the right to decide they will not become pregnant or have a baby and options for preventing or ending pregnancy are accessible and available. Third, individuals have the right parent children they already have with dignity and has the necessary social supports in safe environments and health communities without fear of violence from individuals or the government. Finally, individuals have the right to disassociate sex from reproduction and that health sexuality and pleasure are essential components to whole and full human life.[3]
- I use the World Health Organization's definition of Sexual and Reproductive Health: "Sexual health is an integral part of overall health, well-being and quality of life. It is a state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled."[4]

I. Impact on Public Health Goals (and more specifically why the proposed rule change is a direct violation of principles of reproductive justice).

Ensuring all people of reproductive age can achieve their reproductive life goals is an essential component of public health. Additionally, Reproductive Justice (RJ) is essential to bodily autonomy, human rights principles, and existential liberation for all humans. Reproductive Justice (RJ) is is simultaneously a theory, practice and a strategy that is grounded in four principles. Simply put, RJ posits that every person has the right to decide if and when to

become pregnant and to determine the conditions under which they will birth and create families. Next, every person has the right to decide they will not become pregnant or have a baby and options for preventing or ending pregnancy are accessible and available. Third, individuals have the right parent children they already have with dignity and has the necessary social supports in safe environments and health communities without fear of violence from individuals or the government. Finally, individuals have the right to disassociate sex from reproduction and that health sexuality and pleasure are essential components to whole and full human life.[3] Therefore, academicians, activists, clinicians, researchers, and scholars, believe that Title X, like Title V are essential components to achieve reproductive justice.

There are currently 4,000 entities designated as Title X grantees and 40% are Planned Parenthood health facilities. Half of the people served at Title X clinics are people of color.[1] Nurses (nurse practitioners, nurse midwives and public health nurses) have been the mainstay of sexual and reproductive health care, including in Title X and Planned Parenthood centers, and provide crucial access for vulnerable and low-income populations.[5] These clinics also provide training for nursing and medical students — clinic closures will reduce the pipeline of appropriately trained clinicians.[1]

Additionally, federal funding for low-income individuals who seek family planning services affirms one of the most basic human rights – bodily autonomy. The right to bodily autonomy has been recognized in both life and death. One of the reasons why even when you are dead, informed consent is required for organ and tissue donation.[6]

Next, Title X grantees provide a wider range of services consistent with public health priorities that are aligned with, but not unique to family planning. Pregnancy spacing, allowing individuals to be as healthy as possible prior to becoming pregnant including preconception wellness are known interventions that impact preterm birth (born too soon) and infant mortality. Additionally, screening for sexually transmitted infections including HIV, and care of lesbian, gay, bisexual, transgender, queer, intersex, asexual, and agender individuals are priority areas for public health. It is already known that zip code impacts one's health more than their genetic code.[7] It is essential that poverty be addressed using a lifecourse approach[8] to ensure all people with the capacity for pregnancy be able to attain their person and reproductive life goals.

These rule changes force providers into an impossible choice: Will we care for the pregnant person in front of us and make a requested referral for abortion related services, or will we accept funds allowing us to care for thousands of others? The new rule also imposes cumbersome physical and financial demands on abortion providers who receive Title X funds, which further limit access to abortion care. The proposed changes to the rule are not about "paying for abortion"—rather, if directly asked for an abortion referral, providers would have to respond that as a Title X grantee, we cannot refer them, and we would be limited instead to providing a resource list of comprehensive providers without specifying whether they offer abortion services. **But this rule does mean that we cannot support our patients to make the best decision for themselves and their lives.**

II. The Professional and Ethical Responsibilities of Providers and the Confidentiality and Privacy Issues Associated with the Rule Change for Patients.

The new Title X rules proposed by the current administration means federally funded family planning clinics can no longer refer a patient for abortion and must maintain a "clear physical and financial separation" between services funded by the government and any organization that provides abortions or abortion referrals. This component of the proposed rule change is extremely concerning and problematic for two distinct reasons: 1) potential loss of privacy and confidentiality – including Health Insurance Portability and Accountability Act (HIPAA) of 1996; 2) the violation of informed consent.

Co-location of health services has been shown to be both cost effective and improve health outcomes. This has been particularly true in the context of comprehensive cancer services.[9] My use of oncology and cancer as an exemplar is not by accident. My dissertation entitled *An Evaluation of the Molecular Species of CA125 Across the Three Phases of the Menstrual Cycle* specifically examined the CA125 biomarker that is used to distinguish benign from malignant masses of the ovary and is used to monitor epithelial ovarian cancer. I published 5 manuscripts from this work.[10-14] It has long been understood that the tumor growth and development is biologically similar to pregnancy and that most of the pathways used at a molecular level are similar. A paradigm shift was developed in cancer research to understand that comprehensive and systems approaches would accelerate discoveries and reduce costs. The proposed rule change is inconsistent with this trend in other health services provision – and creates unnecessary and costly silos.

Additionally, comprehensive family planning services have been offered with abortion services and vice versa to center patient needs and reduce the undue burdens of multiple visits, additional costs for childcare, and transportation. If facilities are to develop "clear physical and financial" separation, for many Title X grantees this may mean creating separate physical clinic spaces and therefore inadvertently violating privacy. For example, in the clinical environment where I work, sending patients to different space for clinical services in and of itself could violate their rights to privacy – whether it's accessing a different unit, floor, space or building. Additionally, if different forms, paperwork, electronic health records or other documentation of care provided needs to be distinguished from other types of care, this creates unnecessary redundancy, cost, and other potential violation of privacy.

The proposed rule change violates the American Nurses Association's (ANA) Code of Ethics[15] that reads: "ANA has historically advocated for the healthcare needs of all patients, including services related to reproductive health. ANA believes that healthcare clients have the right to privacy and the right to make decisions about personal health care based on ***full information and without coercion***. Also, nurses have the right to refuse to participate in a particular case on ethical grounds. However, if a client's life is in jeopardy, nurses are obligated to provide for the client's safety and to avoid abandonment. This rule would clearly limit the capacity of nurses to provide fully informed consent."

Finally, the patient-provider relationship is inherently one of unequal power: The patient is seeking expertise, in many cases, from a person with the power to act as a gatekeeper. That power imbalance is often intensified by class, health literacy, race, sexual orientation and gender identity differences between providers and patients—with potentially catastrophic consequences.[2] The successful patient-provider relationship relies on trust: in state and federal regulations, in accrediting organizations and in the provider acting in partnership with the patient. The proposed rule changes to Title X destroys that fragile balance between power and trust.

All of the major U.S. nursing organizations (American Academy of Nursing, American Nurses Association, American College of Nurse-Midwives, Nurse Practitioners in Women's Health) have joined with other professional organizations (American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Adolescent Health and Medicine) to denounce the proposed rules for placing providers in ethically compromising positions and threatening quality of care.[1]

III. How the Rule Change Stymies Innovation & Increases Healthcare Costs.

The expertise of Title X grantees cannot be replicated in any other healthcare entity that currently exists. This clinical expertise in non-directional counseling,[16] decisional assessment,[17] and shared decision-making[18] has been a true innovation in team-based care approaches. Led by nurses, counselors, medical assistants, physician assistants, midwives, and physicians, this expertise has the potential to be lost – after almost 50 years of cost-effective care. Particularly, when it is known that for every dollar spent on family planning save $5 to $7 in later healthcare and service costs.[19]

Title X clinics already adhere to standards for quality family planning[20] developed by the Centers for Disease Control and Prevention and the Office of Population Affairs. These new regulations do nothing to improve quality of care, access or cost. Instead, they will degrade quality and access while adding costs due to delayed or unavailable care. To best serve the public, rule changes should be based on evidence, the highest standards of care and improving the health of our nation; not political ideology.

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Ms. DEGETTE. Thank you so much, Doctor.

Dr. Perritt, I am now pleased to recognize you for five minutes for purposes of an opening statement.

STATEMENT OF JAMILA PERRITT, M.D.

Dr. PERRITT. Thank you so much, Chairman Pallone, Chair DeGette, Ranking Member Guthrie, and members of the subcommittee.

My name is Dr. Jamila Perritt and I am a board-certified, fellowship-trained obstetrician and gynecologist, and a fellow with the Physicians for Reproductive Health. I am here today to give voice to the people I take care of, a voice that is often missing from the rhetoric in the political theater that we see during these debates.

Whether rural or urban, young or old, all of my patients share one thing in common. They are making thoughtful and sometimes difficult decisions about their health and about their well-being. The patient-provider relationship relies on trust and open and honest communication. These rules will compromise that trust and result in substandard care for the communities that already experience discrimination and inequities in healthcare and healthcare delivery, like the communities I serve. It goes against everything I know as a physician and against the oath that I took when I began this work.

As a kid, I dreamed of becoming a doctor and, in fact, I have never wanted to be anything else. I studied for 20 plus years to do this work and I was taught in medical school to respect the agency and the autonomy of my patients. A shared understanding and communication of the risks, benefits, and alternatives to any options for care undergirds this process and is my professional duty.

We heard Congressman Luján mention the American College of Obstetricians and Gynecologists Code of Professional Ethics, which states, and I quote, that "the patient-physician relationship is essential to the focus of all ethical concerns." ACOG also requires OB/GYNs to serve as the patient's advocate and exercise all reasonable means to ensure that appropriate care is provided to the patient."

This new rule directly violates these principles and that is why leading medical organizations oppose it.

Whether I am talking with my patients about options for birth control, prenatal care and birth care, or pregnancy, I am ethically bound to make sure that they have all the information they need to understand and access their options. When speaking about pregnancy, that means answering questions about carrying a pregnancy to term and parenting, putting the child up for adoption, or ending a pregnancy. My patients trust me to give them the information they need and request; and I trust them to make the decisions that are right for them.

These new rules will not allow me to deliver ethical and quality care. The Federal Government is telling providers what we can and cannot say to our patients. It is telling my patients what they can and cannot hear from their doctors. It is ordering me to deprive my patients of information they need, even if they request it. It is an attempt to strip from my patients their basic human rights.

I share Chairman Pallone's earlier voiced concern regarding the equally as problematic focus of this rule on organizations that may offer one method of family planning disguised as comprehensive coverage, such as fertility awareness-based methods at the expense of others. Although fertility awareness methods may be right for some, any women's health provider can tell you that birth control and pregnancy prevention is not one size fits all. Everyone deserves access to the full range of contraceptive methods. And it is only through having a choice of methods that someone can decide what is right for them and avoid the pressure and coercion that comes with being offered only one class of methods.

I can remember a patient I cared for who was seeking birth control. She was a mother of small children and worked at night so she could provide care for her children during the day and be home when her oldest got in from school. She was seeking a birth control option but was concerned because she had tried just about everything and nothing worked. Her high blood pressure prevented her from using some method like pills. She had side effects from other methods like the shot. And ultimately, she settled, like Dr. McLemore, on an IUD because it helped to prevent pregnancy; and also had the benefit of helping manage her heavy periods.

My patient would not have been able to afford this method without being seen at a clinic where I provide care and she received funding through the Title X program.

Dr. McLemore discussed reproductive justice, a vision where the lives of historically marginalized communities and individuals are essential to the fight for equity and justice. It is grounded in an understanding of reproductive health and autonomy as basic human rights.

What I want us all to understand is that no one is making decisions about their reproductive health in a vacuum. Our lives are intersectional. These new rules not only contradict professional ethics and practice guidelines, they perpetuate a system of injustice. They make it clear that if you are an individual with a low income in need of services, you will be getting substandard care. They tell me if you are poor, you are less deserving. When you desire information, you won't get it. This is not healthcare. This is manipulation, punishment, and coercion.

Please protect individuals in the Title X program and their access to high-quality care. My patients deserve it.

[The prepared statement of Dr. Perritt follows:]

Testimony of Jamila Perritt, MD, MPH, FACOG
Fellow, Physicians for Reproductive Health
before the House Committee on Energy & Commerce,
Oversight and Investigations Subcommittee
June 19, 2019

Good morning Chairman Pallone, Chair DeGette, Ranking member Guthrie, and members of the subcommittee. I'm here today to speak with you about the work I do every day and the impact that it has on the patients I care for and care about. My name is Dr. Jamila Perritt. I'm a board-certified, fellowship-trained, obstetrician and gynecologist. I have a comprehensive background in family planning and reproductive health and I am a fellow with Physicians for Reproductive Health, which is a network of doctors across the country that works to improve access to comprehensive reproductive health care. I am also a fellow of the American College of Obstetricians and Gynecologists (ACOG). I am here today to give a voice to the people I take care of every day who are working to manage their reproductive lives. Whether they are ready for a family, already parenting, or focused on their education and career, all of my patients share one thing in common – they are making thoughtful and sometimes difficult decisions about their health and well-being and they all deserve high quality health care. I believe that it is my job to provide it.

In March, the current administration finalized its new rules governing Title X, the nation's only dedicated federally funded family planning program. One of the things that the rule did was to eliminate the requirement of non-directive pregnancy options counseling. This new rule is incredibly problematic. Not only is it unethical, as a physician, I can tell you that it is harmful to the patient-provider relationship, one that relies on trust and open and honest communication. These rules will result in substandard care for communities that already experience discrimination and inequities in health care delivery and health outcomes, like the communities I care for. In short, it goes against everything I know as a physician and against the oath that I took when I began this work.

As a kid, I dreamed of becoming a doctor. I never wanted to be anything else. I studied for years to become a doctor and do this work, 20 plus years in fact. I have taken care of sick people and well people. I have cared for sisters, mothers and friends. I have held the hands of fathers and brothers who were caring for and worrying about their daughters and wives. I took an oath to provide compassionate care to those who need it and to uphold the tenets of my training as a physician.

I was taught in medical school and throughout my training to respect the agency and autonomy of my patients during the medical decision-making process. A shared understanding and communication of the risks, benefits and alternatives to any options for care undergirds this process and is a critical part of my job and professional duty. As an obstetrician and gynecologist, my practice is governed by professional ethics and my commitment to uphold them. The American College of Obstetricians and Gynecologists (ACOG) Code of Professional Ethics unequivocally states that "the patient-physician relationship is the central focus of all

ethical concerns, and the welfare of the patient must form the basis of all medical judgments." ACOG also requires ob/gyns to "serve as the patient's advocate and exercise all reasonable means to ensure that appropriate care is provided to the patient." The new rule directly violates these principles. That is why leading medical organizations oppose them including ACOG, the American Medical Association, the American Nurses Association, the American Academy of Pediatrics, the American College of Nurse-Midwives, and the American College of Physicians.

Information is a cornerstone of the relationship I have with my patients. Whether I am talking with them about options for birth control, prenatal care and birth care, or pregnancy, I am ethically bound to make sure they have the information they need to understand the risks, benefits, and alternatives of their options. When speaking about pregnancy, that means answering questions about carrying a pregnancy to term and parenting, giving the child up for adoption, or ending a pregnancy. My patients trust me to give them the information they need and request, and I trust them to make the decision that is right for them. I have always been able to talk to my Title X patients about abortion and make referrals when needed; but now providers will have to withhold this information which will badly damage their relationships with their patients.

The new rule flies in the face of everything I know about delivering ethical and quality care. The federal government is telling me and other providers what we can and cannot say to our patients. It is telling my patients what they can and cannot hear from their doctors. It is ordering me to deprive my patients of information they need, even if they request it. It is an attempt to strip from my patients their basic human rights. There is no other profession where this occurs. There is no other field of medicine where non-medical providers can dictate how medicine is practiced and what health care we, as physicians, can provide.

Let me be clear. Abortion is health care. Sadly, the federal government denies insurance coverage for abortion in most circumstances. I live in and provide care in the District of Columbia which is prevented from covering abortion with its local revenue, despite District resident support of this coverage. I see the impact of this discriminatory policy on my patients all the time. This rule goes even further. It denies millions of people who depend on Title X, people with low-incomes, not just access to care, but also basic information about a safe and legal option for their pregnancy. We have created, allowed, and perpetuated a two-tiered system of health care, dictated by one's income, socio-economic status and zip code.

This rule would disqualify health centers that provide comprehensive information and care, like Planned Parenthood, from participating in Title X. Planned Parenthood cares for 41% of Title X patients. Fifty-six percent of Planned Parenthood health centers in the United States are in health professional shortage areas, rural, or medically underserved areas. Millions of people rely on clinics like Planned Parenthood for cancer screenings, breast exams, STI treatment, and contraception. Should the rule ever go into effect, communities that are already underserved and have the worse health outcomes, will have even less access to health care with far-reaching impacts that will fall hardest on women with low-incomes, young people, and communities of

color. The centers still participating in Title X will be offering substandard care if they cannot provide full information and options to their patients.

Another problematic aspect of the rule is the focus on organizations that may only offer one method of family planning, such as fertility awareness-based methods, at the expense of others. Although fertility awareness methods may be right for some, any women's health provider can tell you that birth control and pregnancy prevention are not one-size-fits-all. Everyone seeking health care deserves access to the full range of contraceptive methods. It is only through having a choice of methods that someone can decide on the right one for them and avoid the pressure and coercion that can come with only being offered one method. My patients deserve the same options to manage their fertility as you or I would be afforded should we consult with our provider.

I cared for a patient recently who was seeking birth control. She was a mother of small children. She worked at night so that she could provide care for her children during the day and be home when her oldest got home from elementary school. She was seeking birth control but was concerned because in her words she had "tried just about everything that was out there and nothing worked." Her high blood pressure prevented her from using some methods, like birth control pills. She had side effects from other methods, like the birth control shot. Ultimately, after careful counseling and consideration, she settled on an intrauterine device, an IUD, which would help her prevent pregnancy and had the added benefit of helping to manage her very heavy periods.

I am alarmed that the new rules could allow more providers that only offer a single contraceptive method, or very limited methods to participate in Title X, putting at risk access to the most effective – and often most expensive – forms of contraception, such as the IUD this patient selected. My patient would not have been able to afford this method without being seen at the Planned Parenthood where I provide care through Title X funding. She was working to manage all of the intersecting inequities in her life - lack of educational opportunity, having a low income, being uninsured. We cared for her without judgement.

When twelve Black women came together in 1994 to describe a future for reproductive health and rights in this country they sought a broader vision where the lived experiences of historically marginalized communities and individuals are central to the fight for equity and justice. This framework, that we call reproductive justice, is grounded in an understanding of reproductive health and autonomy as basic human rights. It means that every woman has the human right to have children and to determine the circumstances under which she gives birth; the human right not to have children and to have the information and resources she needs to prevent or end a pregnancy; and the human right parent the children we have in safe and sustainable communities. These rights are indivisible. They are inalienable. Whether we are talking about people with low-incomes, young people, or people of color, what I want us all to understand is that no one is making decisions about their reproductive health in a vacuum. Our lives are intersectional – our identities and our lived experiences factor into decisions around contraceptive use, pregnancy, and abortion. Job security, immigration status, educational levels

and goals, neighborhood safety and more all factor into my patients' decision-making processes and are intertwined with whether and how they seek care. The new rules not only contradict professional ethics and practice guidelines, they perpetuate a system of injustice.

Taken as a whole, these rules make it clear that if you are an individual with low-income in need of Title X services, you will be getting substandard care. They tell me that if you are poor, you are less deserving of high-quality care; that when you desire information about abortion, the government will say you are not allowed to have it; that when you desire a method of contraception other than fertility awareness, you can be told "no." This is not health care. This is manipulation. This is punishment. This is coercion.

I encourage lawmakers to take steps to protect individuals in the Title X program and their access to high quality health care. My patients deserve it.

Ms. DEGETTE. Thank you, Doctor.

And I would now like to recognize for five minutes, for purposes of an opening statement, Ms. Foster.

STATEMENT OF CATHERINE GLENN FOSTER

Ms. FOSTER. Thank you, Chairwoman DeGette, Ranking Member Guthrie, and members of the committee.

I am Catherine Glenn Foster, President and CEO of Americans United for Life; America's original national pro-life organization and leader in life-affirming law and policy.

I want to emphasize two key points today, both of which I elaborate on in greater depth in my written testimony. First, Congress acted intentionally when it excluded abortion from Title X. Second, challenges to the HHS rule are rooted in the desire to cast aside congressional intent and use Title X funding for abortion-related services.

First, Congress enacted Title X of the Public Health Service Act in 1970 to provide financial support for healthcare organizations offering pre-pregnancy family planning services. Since 1970, the Act, through Section 1008, has explicitly excluded abortion from the scope of family planning methods and services.

Let me underscore, Congress has statutorily excluded abortion from the scope of Title X projects.

Consistent with the U.S. Supreme Court's decision in *Rust* v. *Sullivan*, the HHS rule at issue requires physical and financial separation between Title X projects and abortion-related activities.

Second, today's challenges to the HHS rule are rooted in the desire to cast aside congressional intent and use Title X funding for abortion-related services. Any consideration of access to abortion should carry no legal weight because Title X explicitly excludes abortion from the scope of its projects.

It is worth asking why Plaintiffs did not raise a legal challenge to the HHS rule based on the undue burden rationale. The answer is plainly because the scope of the abortion right, as discovered in the constitution by seven men in *Roe* v. *Wade*, includes neither a right to public funding for abortion nor a third party's right to provide abortion.

If you listen to the rhetoric of my sisters sitting beside me today, you could be forgiven for thinking that abortion represented some public good. The hand-waving, the euphemisms, and the, frankly, tired rhetoric that I have heard today not only obscures the constitutional realities surrounding Title X but worse, it obscures the truth about what they seek to promote: abortion.

Men and women who advocate for abortion share a strange kind of faith. They believe that women's own empowerment demands the disempowerment of another. We never become stronger, as women, when we abort our own children. I know this, both because I am a mother and because I lived with the regret of having been coerced into an abortion.

I bear the marks of trauma from abortion. But as a woman, I can tell you that my autonomy and empowerment are not a result of the violence and self-harm of abortion, a violence and self-harm which too many seek to perpetuate and to normalize.

Abortion can never be considered a form of family planning because thriving families are characterized by their living members and the life they share in common. Abortion can never be legitimately considered a form of family planning because what defines a successful abortion is a dead member of the human family full stop. There is no way around this reality.

Twenty years ago, a younger Donald Trump appeared on Meet the Press and assured Tim Russert that he was, "pro-choice in every respect and as far as it goes."

Today, President Trump has been described by some as America's most pro-life President. If President Trump can show the courage to admit that he was wrong and to embrace life, I believe that there is hope that perhaps some here today might be similarly willing to look past ideology and to confront the reality of abortion, too. Every American, and especially every woman, deserves better than abortion.

In closing, let me underscore: Congress was clear when it enacted the Title X program in 1970 and Congress has not deviated. The intent was clearly to exclude abortion. The HHS rule adds accountability and transparency to the Title X program. The HHS rule is sound public policy and the HHS rule can withstand constitutional scrutiny.

Thank you.

[The prepared statement of Ms. Foster follows:]

CATHERINE GLENN FOSTER, M.A., J.D.
President and CEO, Americans United for Life

Hearing of the House Subcommittee on Oversight and Investigations,
Committee on Energy and Commerce
"Protecting Title X and Safeguarding Quality Family Planning Care."

June 19, 2019, 10:00 a.m.
John D. Dingell Room, 2123 Rayburn House Office Building

June 19, 2019

Dear Chairwoman DeGette, Ranking Member Guthrie, and Members of the Committee:

I am deeply privileged to testify before this Committee on Title X and the Department of Health and Human Services rule regarding eligibility and use of Title X funding. I serve as President & CEO of Americans United for Life (AUL), America's original and most active pro-life legal advocacy organization. Founded in 1971, two years before the Supreme Court's decision in *Roe v. Wade*, AUL has dedicated nearly 50 years to advocating for comprehensive legal protections for human life from conception to natural death. AUL attorneys are highly-regarded experts on the Constitution and legal issues touching on abortion and are often consulted on various bills, amendments, and ongoing litigation across the country.

It is AUL's longstanding policy position that public funds appropriated or controlled by federal and state governments should not be allocated to providers of elective abortions, but instead should be allocated towards comprehensive and preventive women's health care providers. In furtherance of its mission, AUL seeks to maintain the constitutionality of laws restricting public funds from subsidizing abortion businesses and advocate against the creation of new precedents that would undermine the permissible policy choices of federal and state governments. To that end, AUL filed a Comment in support of the Rule during the public notice and comment period.[1] AUL has also filed amicus briefs in every Supreme Court case involving the rights of states and the federal government not to use public funds and resources to subsidize elective abortions or abortion providers.[2]

Congress acted intentionally when it excluded abortion from Title X.

Congress enacted Title X of the Public Health Service Act in 1970 to provide financial support for healthcare organizations offering prepregnancy family planning services.[3] Title X funds are allocated specifically to projects that "offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility

[1] *See* Comment from Rachel N. Busick, Staff Counsel, Ams. United for Life, to Alex M. Azar, Secretary, U.S. Dep't Health & Human Servs., on Proposed Rule to Ensure Compliance with Statutory Program Integrity Requirements in Title X of the Public Health Service Act (July 31, 2018), https://aul.org/wp-content/uploads/2018/07/AUL-Comment-on-Title-X-Proposed-Rule-re-Program-Integrity.pdf.
[2] *See, e.g.*, *Rust v. Sullivan*, 500 U.S. 173 (1991); *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989); *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977).
[3] *See* 42 U.S.C § 201 et seq.; *Rust v. Sullivan*, 500 U.S. 173, 190 (1991) ("It is undisputed that Title X was intended to provide primarily prepregnancy preventive services.").

services, and services for adolescents)."[4] Section 1008 of the Act (also enacted in 1970) explicitly excludes abortion from the scope of "family planning" and states that "[n]one of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."[5] Likewise, the 2019 Continuing Appropriations Act also explicitly conditioned the allocation of Title X funds to family planning projects provided that the funds "shall not be expended for abortions" and "that all pregnancy counseling shall be nondirective."[6] Thus, Congress has statutorily excluded abortion from the scope of Title X projects and Title X funding, and any discussion of abortion must be nondirective.[7]

In *Rust v. Sullivan*, the Supreme Court held that Section 1008 was ambiguous enough to allow for multiple permissible interpretations, including the regulations at issue in *Rust*, which, similar to the Rule at issue here, required the physical and financial separation between Title X projects and abortion-related activities and prohibited referrals for abortion.[8] As such, it cannot be unreasonable, let alone arbitrary and capricious as claimed in the lawsuits filed against the Rule, for the U.S. Department of Health and Human Services (HHS), under a new administration with different priorities and goals, to disagree with a prior administration's interpretation of an "ambiguous" section with multiple permissible interpretations.

Consistent with *Rust* and in accordance with Title X's statutory mandates, HHS issued the Rule, in part, to "ensure compliance with the statutory requirement that Title X funding not support programs where abortion is a method of family planning."[9] The Rule requires "clear physical and financial separation between a Title X program and any activities that fall outside the program's scope," such as programs or facilities where abortion is a method of family planning, and prohibits directive pregnancy counseling and referrals for abortion.[10]

While Congress has permitted (but not required) nondirective counseling for pregnant women within a Title X project, generally speaking, Title X is focused on prepregnancy family planning services and does not cover post-conception care (outside emergency situations).[11] Regardless of whether a woman is receiving prepregnancy services, nondirective pregnancy counseling, or referrals for care outside the scope of Title X, Title X funds are statutorily prohibited from being used for abortion or in programs where abortion is a method of family planning.

Challenges to the Rule are rooted in the desire to use Title X funding for abortion-related services.

The organizations challenging the Rule in the courts and in the court of public opinion show their hand. Their concerns about abortion reveal that the heart of their legal challenge is

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[4] 42 U.S.C § 300(a).
[5] *Id.* § 300a-6.
[6] Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. No. 115–245, div. B, tit. II, 132 Stat. 2981, 3970–71 (2018).
[7] 65 Federal Register 41273. ("Grantees may provide as much factual, neutral information about any option, including abortion, as they consider warranted by the circumstances, but may not steer or direct clients toward selecting any option, including abortion, in providing options counseling").
[8] *See* 500 U.S. at 187, 203.
[9] 84 Fed. Reg. 7714, 7715.
[10] *Id.* at 7715–17.
[11] *See id.* at 7788–89.

really about access to abortion and coercing HHS to permit abortion services within Title X projects, despite and contrary to Congress' statutory prohibition. The remedy Plaintiffs seek is an injunction against the Rule so they can continue to receive Title X funds (which are prohibited from going to abortion) while still providing abortions in the same physical location as their Title X services and direct abortion referrals within their Title X projects.[12]

But any consideration of access to abortion should carry no legal weight since Title X explicitly excludes abortion from the scope of its projects and funding and Plaintiffs did not raise a legal challenge based on an undue burden to a woman's abortion choice. The latter is unsurprising considering that a woman's "right" to abortion neither includes a right to public funding for it, nor a third party's right to provide it. It is well established that "the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual."[13] This includes abortion. "There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy."[14] That is why the Supreme Court has consistently upheld the power of federal and state governments to "make a value judgment favoring childbirth over abortion, and . . . implement that judgment by the allocation of public funds."[15] Both Title X and the Rule implement Congress' "value judgment favoring childbirth over abortion."

Challengers claim the Rule will force grantees out from Title X.

Challengers to the Rule claim the rule will force or drive out Title X grantees from Title X, harming those who use the program as a health resource.[16] First of all, underlying this claim is

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[12] *California v. Azar*, No. 19-1184 (N.D. Cal. Apr. 26, 2019); *Essential Access Health, Inc. v. Azar*, No. 19-1195 (N.D. Cal. Mar. 21, 2019); *Oregon v. Azar*, No. 19-317 (D. Or. Mar. 29, 2019); *Washington v. Azar,* No. 19-3040 (E.D. Wash. Apr. 25, 2019); Brief Amicus Curiae of Ams. United for Life in Support of Appellants and Reversal, *California v. Azar*, Nos. 19-15974 (9th Cir. June 7, 2019) https://aul.org/wp-content/uploads/2019/06/AUL-CA-Title-X-Amicus-Brief.pdf; Brief Amicus Curiae of Ams. United for Life in Support of Appellants and Reversal, *Essential Access Health, Inc. v. Azar*, & 19-15979 (9th Cir. June 7, 2019) https://aul.org/wp-content/uploads/2019/06/AUL-CA-Title-X-Amicus-Brief.pdf; *Oregon v. Azar*, No. 19-35386(L) (9th Cir. June 7, 2019) https://aul.org/wp-content/uploads/2019/06/AUL-OR-Title-X-Amicus-Brief.pdf; Brief Amicus Curiae of Ams. United for Life in Support of Appellants and Reversal, *Washington v. Azar*, No. 19-35394 (9th Cir. June 7, 2019) https://aul.org/wp-content/uploads/2019/06/AUL-WA-Title-X-Amicus-Brief.pdf; Brief Amicus Curiae of Ams. United for Life in Support of Defendants and in Opposition to Plaintiffs' Motion for Preliminary Injunction, *Family Planning Ass'n of Me. v. U.S. Dep't of Health & Hum. Servs.*, No. 19-100 (D. Me. Apr. 17, 2019), https://aul.org/wpcontent/uploads/2019/04/AUL-Amicus-Brief.pdf.

[13] *Webster*, 492 U.S. at 507; *see also Regan v. Taxation with Representation of Wash.,* 461 U.S. 540, 549 (1983) ("[A] legislature's decision not to subsidize the exercise of a fundamental right does not infringe the right.").

[14] *Maher*, 432 U.S. at 475.

[15] *Rust*, 500 U.S. at 192–93 (quoting *Maher*, 432 U.S. at 474).

[16] *See, e.g.*, Cal.'s Notice of Mot. & Mot. For Prelim. Inj., with Mem. of Points & Auths., *California v. Azar*, No. 19-1184 (N.D. Cal. Mar. 21, 2019) ECF No. 26 at 1 [hereinafter Cal. Prelim. Inj. Mot.] ("The Final Rule will push out many well- qualified providers . . . ."); Pl.'s Notice of Mot. & Mot. for Prelim. Inj., *Essential Access Health, Inc. v. Azar*, No. 19-1195 (N.D. Cal. Mar. 21, 2019) ECF No. 25 at 2 [hereinafter EAH Prelim. Inj. Mot.] ("[P]roviders will be forced out of the program."); *id.* at 18 ("Title X providers nationally would feel compelled to leave the Title X program . . . ."); *id.* at 27 (The Rule will "forc[e] [many subrecipients] out of the network."); Order Granting in Part & Denying in Part Pls.' Mots. for Prelim. Inj., *California v. Azar*, No. 19-1184 (N.D. Cal. Apr. 26, 2019), ECF No. 103 at 16 [hereinafter Cal. Prelim. Inj. Order] ("[T]he Final Rule threatens to drastically reduce access to the wide array of services provided by Title X projects by driving large numbers of providers out of the program."); *id.*

the assumption that Title X grantees will dogmatically choose abortion over their Title X services. This outcome is far from certain. All grantees have the ability to physically and financially separate services, something they should have already been doing. Moreover, HHS has made the determination that even if some grantees choose to leave Title X, others will likely fill their place.[17] HHS listed as goals for the program under the new Rule: "reaching more unserved or underserved areas, increasing innovation within the program, [and] expanding diversity of grantees and partners."[18] The Rule does not require every grantee to provide all Title X services, as long as the overall Title X project offers a broad range of services. This increases the pool of applicants and allows the government to choose the best-qualified applicants for specific services instead of settling for a single sub-par applicant who happens to provide more services. This also allows for participation by organizations who have a conscience objection to certain Title X services, but provide excellent service in other Title X areas. This more inclusive approach creates opportunity for greater access to Title X services generally. Through this Rule, HHS is taking steps to ensure that any grantees who choose to withdraw from participation are replaced by qualified providers.

Second, the Rule does not force Plaintiffs out of Title X projects. Title X grantees who provide abortion services are not automatically excluded or eliminated from Title X. Rather, grantees simply must adhere to Title X project regulations, which under the Rule requires grantees to provide any abortion services physically and financially separate from their Title X projects and not give any directive abortion counseling or abortion referrals within their Title X programs. If Plaintiffs choose not to comply with the Rule's separation, counseling, and referrals requirements because they want to prioritize their abortion services over their Title X services, that is Plaintiffs' independent business decision, irrespective of the Rule.

Third, Plaintiffs are attempting to coerce HHS into changing its regulations by leveraging their Title X services.[19] But threats to leave a federal program cannot be a basis to enjoin the Rule. Otherwise, a subset of grantees in a federal program could coerce an agency by threatening to leave until the agency changes its regulations to suit the grantees' preferences. If grantees do not want to comply with the regulations, they are free to forego participation in government funded programs.[20]

Moreover, the claim that grantees will have to shut down programs and clinics is revealing.[21] It makes sense that if grantees choose to no longer receive Title X funds, they would

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at 59 ("[L]arge numbers of Title X providers would be forced to leave the program."); *id.* at 20 ("Planned Parenthood has stated unequivocally that its whole network of health centers 'would be forced to discontinue their participation in Title X if the Proposed Rule takes effect.'").

[17] 84 Fed. Reg. at 7780; cf. *Obria Grp., Inc. v. U.S. Dep't of Health & Hum. Servs.*, No. 19-905 (C.D. Cal.) (suit by new grantee network of family planning service providers to enjoin prior Title X regulations requiring abortion referrals so that it will be able to participate in Title X grant programs).

[18] https://www.hhs.gov/about/news/2019/02/22/fact-sheet-final-title-x-rule-detailing-family-planning-grant-program.html

[19] *See, e.g.*, Cal. Prelim. Inj. Order at 16 ("The net effect of so many providers leaving Title X will be a significant reduction in the availability of important medical services.").

[20] *See Rust*, 500 U.S. at 199 n.5 (Title X grantees are "in no way compelled to operate a Title X project; to avoid the force of the regulations, [they] can simply decline the subsidy.").

[21] *See, e.g.*, Cal. Prelim. Inj. Mot. at 20 ("Loss of Title X funding will cause clinics to reduce hours of operation, eliminate transportation or off-site locations currently offering services at times and places convenient to certain patients, and undermine the long-term financial stability of some family planning clinics, especially in rural

have to stop providing Title X-funded services. What does not make sense is why they would have to stop receiving Title X funding in the first place. If their Title X projects or clinics do not provide prohibited abortion services, then they would not need to forego Title X funds. But if their Title X projects or clinics do provide prohibited abortion services, then to admit that they would have to shut down the entirety of those projects or clinics is to admit that Title X funds are used to support their abortion services. Otherwise, even if abortion services are offered in conjunction with Title X services, but not within a Title X project, there should be no need to stop the abortion services or close the clinic if they choose to leave Title X, unless the Title X funds are being used to support their abortion services. Any claims of program and clinic closures that include services beyond Title X support HHS's rationale behind the Rule's separation, counseling, and referral requirements, and demonstrate why the Rule's regulations are necessary and beneficial.

Vocal opposition to the Rule, including legal challenges, suggests that some grantees may not have always complied with the separation requirement. Congress was clear when it enacted the Title X program in 1970 and has not deviated; the intent was clearly to exclude abortion. The Rule adds accountability and transparency to the Title X program. It is my legal opinion that the Rule is sound public policy that can withstand constitutional scrutiny. Thank you.

Sincerely,

Catherine Glenn Foster
President and CEO
Americans United for Life

communities."); EAH Prelim. Inj. Mot. at 27 ("Without Title X funds, health centers vital to their communities will reduce services, decrease clinic hours, eliminate staff positions, cut staff training and continuing education, and close satellite sites."); Cal. Prelim. Inj. Order at 16 ("Some [Title X recipients] would have to shut down core services and programs entirely," citing a slew of declarations by various health programs in the state that indicated that the loss of Title X funds would hurt their programs and services.).

Ms. DEGETTE. Thank you, Ms. Foster. I thank the panel.

In accordance with the chair's previous comments, this committee will be recessed pending votes on the floor. They are saying we have 12 votes on the floor. It could be an hour to an hour and a half. So, I suggest you get some lunch.

This committee is in recess.

[Recess.]

Ms. DEGETTE. The committee is reconvened and I just can't thank all of the witnesses enough for staying around while we had our mega vote-a-thon on the floor. I really appreciate it.

The Chair will recognize herself for five minutes for the purposes of questioning. And I would like to start with you, Dr. Perritt.

I know all of you heard Dr. Foley's testimony on the first panel. And what I would like you to do is listen to the questions that I am going to ask you and answer specifically to me what the issues that you have with this rule. And the reason is because if you listen to Dr. Foley, then it is really no big deal. It is just clarifying the statute that was passed in 1980. So we hear this dichotomy between what you are saying, and she is saying, and I would like to clarify.

And I would like to start with you, Dr. Perritt. Dr. Foley testified that health providers can have a complete conversation with their patients about their pregnancy options. From your perspective, as a provider, is that an accurate statement? And if not, what specifically in this rule would prevent providers from having that conversation with their patients?

Dr. PERRITT. Thank you so much. You know it absolutely is not my understanding of what the rule says and it is problematic for a number of reasons.

Ms. DEGETTE. And why is that?

Dr. PERRITT. It is absolutely a gag rule. This theoretical dispensation of information without actual support to achieve these services is not nondirective counseling. So that is a global issue with our ability to actually provide care in a comprehensive way.

And so my understanding is this limitation on your ability to actually provide counseling about all of the options, including providing information regarding referrals, and that is an absolute gag of what I am able to say to my patients is not nondirective counseling. It is in inhibiting their ability to make a decision that is right for them with all of the information.

Ms. DEGETTE. Dr. McLemore, what is your position on that?

Dr. MCLEMORE. I agree with what Dr. Perritt said. And I also would like to also add that I think it is really important that patient-provider relationship is built on trust and trust in the public, especially coming from the perspective of a nurse, means that we will provide you all of your options that are available to you, answer your questions, and be able to center you and your needs to get you the care that you need.

And so if I am having to deal with lying by omission, then I think that is really a problematic breach of trust.

Ms. DEGETTE. So if a patient, for example, came in and said to one of your nurses "I would like information about abortion," but that nurse was personally opposed to abortion, then would you

think that that nurse should have to tell the patient all of their options anyway?

Dr. MCLEMORE. No, we already have protections under the ANA Code of Ethics and I didn't get an opportunity to read this earlier, because I think it is important that I do because I ran out of time, but all nurses have the right to refuse to participate in a particular case on ethical grounds. However, if a client's life is in jeopardy, nurses are obligated to provide for the client's safety and to avoid abandonment.

Ms. DEGETTE. And would the nurse also have to, if they were opposed, refer them to somebody else so that they could give them the information they were asking for?

Dr. MCLEMORE. Correct.

Ms. DEGETTE. And that is what would not happen under this rule.

Dr. MCLEMORE. Correct.

Ms. DEGETTE. Is that correct?

Dr. MCLEMORE. Correct.

Ms. DEGETTE. Ms. Coleman, I wanted to ask you, Ms. Foley seemed to indicate that there wouldn't really be any problem with separating the facilities where there is abortion facilities and family planning facilities in one location because it was only 10 or 20 percent. Is that the view of your members and if not, why not?

Ms. COLEMAN. The rule affects all Title X entities, whether or not they provide abortion care outside of their Title X funds. And the reason that it affects all Title X agencies is because, in addition to requiring physical separation, if you provide abortion care with non-Title X funds, it also says the Title X projects cannot do anything to encourage, promote, support, or advocate for any part of abortion.

So for example, if you are a State Health Department that also monitors abortion care and you monitor the Title X program, you would have to physically separate the building, the staff, the payroll records, the files, everything related to your oversight of abortion care in your State.

Ms. DEGETTE. So this would be far, far more reaching than the Department would seem to indicate.

Ms. COLEMAN. Correct, it does not only affect abortion providers.

Ms. DEGETTE. Ms. Geoffray, I just wanted to ask you very briefly, you saw something like this happen in Texas. What did this do for the provision of healthcare for lower income and rural women?

Ms. GEOFFRAY. So after the funding cuts and the policy changes in 2011, over 50 percent of women that were receiving services at the time lost access to services. What we saw was a discontinuation of contraceptive methods because people did not have access to healthcare services. We saw increases in STI rates. We saw increases in unintended pregnancies. We saw increases in abortion rates. And we, obviously, saw impacts to maternal mortality that had varying causes but there is some belief that access to family planning being lost also impacted that.

Ms. DEGETTE. Thank you so much to all of you.

The ranking member is now recognized for five minutes.

Mr. GUTHRIE. Thank you. And thank you all for being here. We appreciate it very much.

The first thing, I want to ask unanimous consent to include in the record a letter from the Concerned Women for America Legislative Action Committee. I think it was submitted to your staff just previously.

Ms. DEGETTE. Without objection.

[The information appears at the conclusion of the hearing.]

Mr. GUTHRIE. Thank you very much. And thank you very much.

And Ms. Foster, I think I had to learn, started getting ready for this hearing, different terms, nondirective counseling, directive counseling. As Ms. Foley said, she is not a lawyer. I am not a physician as well. We are trying to learn and figure the differences and how it complies with what is important.

The congressional statute, and obviously Congress can always change the statute if they wanted it to be different, as long as you get a majority of the House, the Senate, or a veto-proof majority, obviously, but that is our system.

So, in your definition, what is the nondirective counseling and how does it differ from directive counseling?

Ms. FOSTER. So nondirective counseling would allow for a full discussion of all of the options with any pregnancy. It includes parenting. It includes adoption. It includes abortion. The directive counseling piece would come in when a woman, a girl is being urged in one direction. And we know from whistle blowers that sometimes that does happen. That is a problem.

And so one of the goals of this rule is to prevent directive counseling, while still allowing women and girls to get the full information about their range of options.

Mr. GUTHRIE. So, in your opinion, does the change in the rule from mandatory nondirective counseling to permitted nondirectional counseling better align with the Title X program and its statutory frameworks and requirements?

Ms. FOSTER. Absolutely. And when you look back at Rust v. Sullivan, the 1991 Supreme Court case, what the Supreme Court upheld was in fact more restrictive than this Protect Life Rule. What they upheld was in fact more of a restriction on counseling. This rule says, please, discuss the options, discuss all the range of choices before women and girls that they have to choose from. Simply, don't be directive about it.

Mr. GUTHRIE. OK, thanks. And you know it seems, if you just listen to some of the questioning earlier today and some of the answers with Dr. Foley, that it seems to be hear some saying all we are saying is it is nondirected, nonmandatory, and people have the opportunity to speak with their patient. It is between the patient and the client. That is who it is between and there is nothing directed for them. It is not telling anybody what they can do or can't do.

You know some people were saying this rule tells what they can or can't say to their patient. What is your response to that? It just seems there is two different—there is one set of facts and two different views of the same set of facts.

Ms. FOSTER. Yes, I would say that this rule, one of the primary goals of it is to in fact increase the diversity of providers available to women and girls out there. Because what this does is allow providers, who have not previously been eligible, I am thinking specifi-

cally of Obria, for example, to be included within the Title X program.

And I am thinking also of a dear friend of mine, an immigrant, a young woman, came to the United States, fell in love, was seeking contraception as she planned her wedding. But she is a person of faith and she said you know what, I want a healthcare provider who can match my story, match my background, a healthcare provider who is likewise a person and entity of faith. And you know she had nowhere to turn prior to this rule. She didn't know where to go. She didn't want to go to Planned Parenthood but she didn't know where in fact she could go. And so she really was at a loss under the prior regime.

Now, under the Protect Life Rule, she has options because of what you could call the pooling and the ability of a more diverse field of providers to engage in Title X, and the program, and in the services. So she, thankfully, actually just had her second planned child but she encountered such resistance at the time. It was very disappointing to try to walk with her along that journey and not be able to find a provider who could meet her needs as a young immigrant, low-income woman.

Mr. GUTHRIE. Thanks.

Dr. Perritt, in my opening statement, this has been an important program, Title X, to Kentucky. A lot of people have benefitted from it.

And you said that—I am sorry, I am bout out of time so I hate to ask you a question and only give you a few seconds but you said that this rule tells what you can or cannot say to your patients. What do you have to say to your patients because of this rule and what can you not say? What does it prevent you from doing?

Dr. PERRITT. I think what——

Mr. GUTHRIE. Now that you got the question, I really want the answer.

Dr. PERRITT. I think what Dr. McLemore said really serves it best. These are lies of omission. When we are talking about what we can and cannot say in the office with our patients, this is not a decision that should be held in a body of legislation. These are medical decisions.

You mentioned earlier you are not a doctor. I am. I studied medicine. I practice medicine and I practice in communities that deserve the same care that you and I would get, should we show up to see our provider.

Mr. GUTHRIE. You said it is omission but what can you not say? I guess what would you want to be able to share that you can't share?

Dr. PERRITT. If someone—sure. If someone says I would like an abortion where can I go, I cannot say this is where you can go. That is what I can't say.

Mr. GUTHRIE. Yes, but that is limited in the statute as well, not necessarily the rule. Yes, so it is family planning.

Dr. PERRITT. I disagree.

Ms. DEGETTE. The gentleman's time has expired. We will clarify this.

The Chair recognizes the chairman of full committee, Mr. Pallone.

Mr. PALLONE. Thank you, Madam Chair.

It seems to me that the trust between a provider and a patient is at the heart of quality family planning and I am particularly disturbed by the alarm raised by numerous medical associations and in the testimony today about the devastating impacts the new Title X rule could have on this relationship, if allowed to be implemented.

So as providers yourself, I will go back to Dr. Perritt and Dr. McLemore, I wanted to ask, I will start with Dr. Perritt, why is trust essential to the patient and provider relationship and what role does trust play in supporting that patient's family planning and health needs? I know you talked a little bit but if you would, elaborate.

Dr. PERRITT. Absolutely. I could not imagine showing up to see my provider and have their hands tied regarding the type of counseling for any medical procedure, or any complication, or any condition; anything that I show up for.

So this baseline level of trust means that when a provider—when a patient shows up to my office, then I can have an honest conversation. They don't have to be concerned that my motive is anything different or distracting from what their ultimate desire is.

As a physician, my priority is always my patient. This conversation around promoting abortion in one way or another, the only thing that I promote and prioritize is the healthcare of the community I serve, period.

Mr. PALLONE. And Dr. McLemore, would you agree or do you have anything to add? I mean I think what, if I understand what she is saying, is that you know even what my previous colleague said is true, that you can't even mention or even give information about abortion, that in itself is harmful to the patient provider relationship that you have to limit what you say in any way.

Ms. MCLEMORE. I do. I mean if that is what patients want that is the whole essence of patient-centeredness. It is to be able to ascertain and create a situation where patients can tell us what they need and, as service providers, we can provide them what they need.

I do want to point out that the patient-provider relationship is inherently one of unequal power. And we hold that power in the relationships that we have, you know, with patients. We have information that the public needs. And so if you can't give them the full range of the information that they have to make the choices and decisions that they need to make, I think it really puts us in a bind with potentially catastrophic consequences.

The CHAIRMAN. All right, well, I agree.

Dr. Foley's testimony stated that the new rule, and I quote, "places a high priority on preserving the provider-client relationship." Ms. Coleman, based on your familiarity with both the new rule and Title X providers across the country, do you agree with Dr. Foley's and HHS' contention that the new rule places a priority on preserving the provider-patient relationship, and why, or why not?

Ms. COLEMAN. Mr. Pallone, I would start with the fact that, under this rule, the Title X program which exists to help women

achieve or prevent pregnancy would not require pregnancy counseling at all. The rule would allow it but not require it.

In the National Family Planning Program, meant by Congress to help people prevent or achieve pregnancy, this rule drops out the requirement that you discussed medically approved contraception that are both acceptable and effective to clients. And this rule says that if a patient asked you for a contraceptive method that the provider disagreed with or did not support offering, the provider does not need to mention, the entire entity does not need to include certain types of contraception that the entity or an individual provider finds objectionable.

So for all of those reasons, of course this rule steps into the relationship between a patient and a provider.

Mr. PALLONE. See one of my concerns, and I don't know if I can articulate this, is that this is going to allow so-called providers who don't believe in contraception, who don't believe in abortion, who don't believe in any of the above, to still get Title X funds.

Ms. COLEMAN. Well, they don't get them now under the current rules.

Mr. PALLONE. No, but they would under the new rule.

Ms. COLEMAN. But they will if this rule is applied.

Mr. PALLONE. So you could actually get—you could actually—I mean the way I read this thing, I could go there and say look, the only thing I do is preach abstinence, right, and I want Title X money. They would probably be approved.

Ms. COLEMAN. Certainly, a service site could do that.

It also, I mean the rule itself says a couple of times that entities should be allowed to apply conscience in deciding what the service mix is. And the rule also says that the referral requirements in place now deter qualified providers from participating.

TMr. PALLONE. It is just scary.

Ms. COLEMAN. So it seems very clear the rule was written to open the door to ideological providers and completely walks away from our commitment to be client-centered in family planning care.

Mr. PALLONE. It is such a scary thing to me that you know ideology—it is already a problem but if it gets to that point, it is even you know a worse situation.

Thank you. Thank you, Madam Chair.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

The Chair now recognizes the gentleman from Virginia, Mr. Griffith, for five minutes.

Mr. GRIFFITH. Thank you, Madam Chair.

Dr. McLemore, you state in your written statement that, and I am quoting, "I employ reproductive justice, RJ, as a theory and practice to guide all of my work. And then it goes on to define RJ. Simply put, RJ posits that every person has the right to decide if and when to become pregnant and to determine the conditions under which they will birth and create families."

In the Virginia legislature this year, there was a bill and, in answering questions, Delegate Tran was answering questions being put forward by Delegate Gilbert. Delegate Gilbert asked if under the bill, as it was put forward, if you could have an abortion as late as the time when the mother was already dilated. And the bill went on to say that it could be for any reason, as long as there was

one doctor, even some emotional reason at that late stage, and that there could be an abortion.

Does that fit into your definition of RJ or reproductive justice?

Ms. MCLEMORE. I have to say that the question seems a little off-putting from the context that we are talking about Title X grantees and funding.

Mr. GRIFFITH. Yes, ma'am, and I would not have asked it if you had not included it both in your written statement and in your oral statement to this committee. So I agree it is a little different but——

Dr. MCLEMORE. So here is——

Mr. GRIFFITH [continuing]. You brought it up and so I just want to know the answer. Is that a part of what you consider to be reproductive justice?

Dr. MCLEMORE. Here is the interesting thing about reproductive justice. It is not necessarily so much about what I think. The people who we serve are the experts in their own lives and so they get to decide. It is not about what I think or what I believe. I have reproductive justice as it is defined in my own life. The really great thing about human rights is is that people get to determine what rights they want to exercise within their lives and that they have the capacity to make the decisions that they think are most important.

Mr. GRIFFITH. But do you think then, under Title X, it would be appropriate if somebody had a definition that included up to the point of dilation, that they should be counseled to where they could go get an abortion in that late third trimester? They are already dilated. Should one of the Title X clinics then be counseling them to here is where you go to get that late-term abortion?

Dr. MCLEMORE. I don't think that that is a question that I can answer, given that Title X grantees do not receive monies to be able to provide abortions.

Mr. GRIFFITH. But the issue here today is whether they can make referrals or talk about it. And if reproductive justice, as you have defined it, would include, under some individuals' philosophy, up to the point of I am dilated, I am getting ready to give birth, and I have decided I don't want to.

I mean I know these are tough questions but it was raised by your testimony. That is why I asked.

Dr. MCLEMORE. Well, I think there is a lot more background that would need to be provided. First of all, most abortions, almost 90 percent, happen in the first trimester. Late-term abortions are very, very rare.

Mr. GRIFFITH. I don't disagree with that. But is it really—either it is allowed under your view or it is not allowed.

Dr. MCLEMORE. It wouldn't be my decision to make.

Mr. GRIFFITH. All right, Ms. Foster, what do you say about that?

Ms. FOSTER. I would consider that to be quite concerning, of course.

Mr. GRIFFITH. I thank you very much. I yield back.

Ms. DEGETTE. The gentle lady from Illinois is recognized for five minutes.

Ms. SCHAKOWSKY. So I wanted to put a few things on the record on who actually takes advantage of Title X services. Six out of ten

women seeking contraceptive care at Title X-funded health centers report that center was their only source of care that year.

So this is for comprehensive healthcare that people go to these centers. Sixty-seven percent of Title X participants had incomes at or below the Federal poverty level in 2017. Ninety percent of the Title X patients had incomes at or below 250 percent of the Federal poverty level, which means that they qualified for no-cost or subsidized services. Twenty-two percent self-identified as African American. Thirty-three percent identified as Hispanic or Latino. And finally, forty-two percent of the Title X patients are uninsured. So these programs provide essential services that go-in their settings-beyond just contraception.

But I wanted to ask a couple of things that are really unclear to me. So Dr. Foley was saying that the reason you couldn't co-locate a clinic with any provider of abortion is the opportunity for commingling of funds. And I am wondering if, Ms. Coleman, we have any evidence that the current law has been violated and that there has been a commingling.

Ms. COLEMAN. There is no evidence to support that claim.

Ms. SCHAKOWSKY. I think that is really important to put on the record. The opportunity doesn't mean that there has been some sort of a violation.

There was also an example given of a 13- or 14-year-old who made a mistake. So we are not talking about rape or incest. We are saying this child made a mistake and is pregnant and, then, goes to a Title X clinic with her mom, and asks for information about getting an abortion because she does not want to be pregnant at 13 or 14 years old. The answer was because that was a decision about family planning, that the doctor could not refer her to an abortion clinic. Does that make——

Let me ask Ms. Foster. Does that make sense to you, the child should have that baby because——

Ms. FOSTER. Well, as we discussed previously, Title X was enacted to provide financial support for pre-pregnancy family planning services. So if there was the desire to expand it to family planning services——

Ms. SCHAKOWSKY. Do you think a 13- or 14-year-old should be able to be told by the doctor that she went to with her mom that there is an abortion available for her?

Ms. FOSTER. Well, that would be nondirective counseling and would be eligible under this rule.

Ms. SCHAKOWSKY. No, no, no, it wouldn't because that kind of referral cannot be made, if the abortion is for family planning. That is what this rule says. Am I wrong, Ms. Coleman?

Ms. COLEMAN. I think the important thing to think about is the national standard, the CDC Office of Population Affairs standard says that counseling and referral are part of the same action. So when a provider may or may not offer information and this rule allows a provider simply to be nonresponsive to that adolescent and her parent, the provider would have the opportunity to say I can't help you at all.

So the provider can limit counseling and may not refer. And that is in direct contradiction to this country's own clinical standard that was put in place in April of 2014 and remains in place today.

Ms. SCHAKOWSKY. Is it also possible for that doctor to provide a list of places that does not include abortion services?

Ms. COLEMAN. The rule would allow a provider who chose to offer a patient a list for referral. On that list must be comprehensive primary care providers. There may or may not be an abortion provider included on the list. That would be the choice of the provider and the entity. And the provider, in no case, could identify to the patient if there were an abortion provider listed and if so, which one of the health centers listed was the abortion-providing entity.

Ms. SCHAKOWSKY. Thank you.

I am concerned about this issue of co-locating and the kind of disruption, and I don't know who on the panel can best describe what that would mean. As I said, most—six out of ten women, when they go for contraception, this is their total care. They expect the availability of all the services. And if they are in a place where abortion is provided, what would happen to the clinics around the country if they had to set up a whole separate operation?

Ms. DEGETTE. The gentle lady's time has expired but——

Ms. SCHAKOWSKY. It did?

Ms. DEGETTE [continuing]. We can go back to that.

Ms. SCHAKOWSKY. Oh, I am sorry. OK.

Ms. DEGETTE. The Chair will now recognize Dr. Burgess for five minutes.

Mr. BURGESS. Thank you.

And thank you, Ms. Foster, for pointing out that under Title X it is pre-pregnancy family planning and that is what we are talking about.

So let me ask you if there are any implications of the 2019 final rule that would deter grantees from applying for Title X grants in the future.

Ms. FOSTER. No, and in fact a wider variety, a more diverse population of organizations would be able to apply for Title X grants.

Mr. BURGESS. So you think it would increase then the universe of people offering this service, pre-pregnancy family planning?

Ms. FOSTER. Absolutely. And in fact, applicants who had a conscience objection prior to the 2019 rule, according to the prior requirement the Title X grantees must refer for abortion, can now in fact apply to receive Title X funds.

For example, Obria Group operates a chain of clinics throughout California and was denied in 2018 but would be eligible under the 2019 rule.

Mr. BURGESS. Would you be concerned at all that abortion is a large enough percentage of the business of some grantee services that they would just simply pull out of Title X?

Ms. FOSTER. I would certainly hope not. If an organization chose not to apply for a grant, that would be their choice but every organization who is currently in compliance with the law, would continue to be in compliance with the law.

Mr. BURGESS. So according to the April 2019 Title X directory, Texas has two grantees and 34 sub-recipients. Do you anticipate that this new rule will attract new grant applicants?

Ms. FOSTER. I would expect that it would, yes.

Mr. BURGESS. And ultimately, that would be a good thing. Is that correct?

Ms. FOSTER. Absolutely. If we have a broader diversity of grant applicants and hopefully grantees, then that would be a good thing. We would have a wider variety of options for women to choose from.

Mr. BURGESS. So each State has different needs when it comes to the health and well-being of its citizens. Can you speak to the importance of allowing States the flexibility to choose their own Title X grant recipients?

Ms. FOSTER. Certainly. It is absolutely critical that States have the ability to choose their Title X grant recipients, that we have that diversity and options for women.

Speaking, again, of the friend that I referenced earlier, immigrant low-income women have the same right to access and should be able to access life-affirming choices, if that is what they so choose. They should be able to access a provider that shares their faith background, if they so choose, and that really should be available to women in every walk of life.

Mr. BURGESS. Well, thank you for those responses.

Madam Chair, I would just like to submit for the record a letter to me from Dr. Michael New. Dear Dr. Burgess, I would like to draw your attention data showing overall positive trends in Texas, including a reduction in the number abortions year after year. He is talking about 2011–2015. Between that time frame, the last year for which data is publicly available, the pregnancy rate for minors in Texas fell by 39 percent, the birth rate for minors fell by 36 percent, and the number of abortions performed on minors fell by 53 percent. Additionally, during this time, the overall abortion rates in Texas declined by over 29 percent and the State birth rate exhibited little change.

And this is in the background of—I mean we are growing in Texas. We are getting bigger. The female population age 15 to 44 just under 5,400—I am sorry—5,400,000 in 2011 and is now 5,700,000 in 2015. The female population age 13 to 17 likewise increased significantly between 2011 and 2015. So it is not a declining population that is resulting in these declining numbers. It is providing the timely services, pre-pregnancy family planning.

Thank you very much and I will submit this for the record.

Ms. DEGETTE. So I will just say, in terms of admitting this to the record, as a former trial lawyer, this would never go into the record, since we don't know who Dr. New is or what his methodology was. But having said that, we have a general practice in this committee of admitting letters that go to members.

And so with the caveat that we don't know if any of this data is accurate and, without objection, I will admit it into the record.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. So happily for you, that is referenced in the Department of Health and Human Services——

Ms. DEGETTE. We have admitted it.

Mr. BURGESS [continuing]. With the State of Texas. It is easily verifiable.

Ms. DEGETTE. It has been admitted.

The Chair will now recognize Ms. Castor from Florida for five minutes.

Ms. CASTOR. Well, thank you, Chair DeGette.

In addition to dictating what information Title X providers would or wouldn't be allowed to share with their patients, the administration's new Title X rule appears to undermine evidence-based standards of care. And you heard before lunchtime a lot of discussion. The American Medical Association opposes this. American College of Obstetricians and Gynecologists opposes it. American Family Physicians, American Public Health Association, most of our witnesses today, they oppose this new rule. For example, ACOG and 18 other leading health organizations said of the rule that, "the final Title X regulation disregards expert opinion and evidence-based practices."

Dr. Perritt, do you agree that the final rule disregards evidence-based practices?

Dr. PERRITT. Absolutely. We rely really heavily on the evidence to make medical decisions and to help guide our patients. It violates it without question.

Ms. CASTOR. Do you think that this rule is likely to lead to more unintended pregnancies?

Dr. PERRITT. If we decrease access to comprehensive family planning services, yes, it will lead to decrease access. We heard lots of conversation about hoping that it improves access. We hope that it increases access. We hope that more people get care.

The patients that I take care cannot bank on our hope. They need actual legitimate services that are comprehensive, that are respectful, that respect their agency and autonomy. They deserve that.

Ms. CASTOR. So let's take a step back for a minute and recognize the progress that we have made in the United States of America in decreasing the number of unintended pregnancies. A lot of that success goes right back to Title X because, for about 50 years, we have made every effort to ensure that every woman, no matter where she lives, no matter what her income is, has equal access to contraceptives and can make those family planning decisions with her family, her husband, her faith, the doctors, all the healthcare providers. It has been a tremendous thing. That is why it is just so mindboggling why the administration voices an intent to decrease the number of unintended pregnancies is doing the exact opposite of what should be done. We should be strengthening the healthcare safety-net for women and families.

The Title X, current Title X guidance specifies that projects, "provide a broad range of acceptable and effective medically-approved family planning methods and services." Yet, the administration's new rule would eliminate the term medically-approved.

Ms. Coleman, what signal is the administration sending by eliminating this term?

Ms. COLEMAN. Again, the administration has made clear in the rule that they believe that entities applying for Title X and providers who work in those entities should be able to choose according to their own preferences and beliefs what range of contraceptive methods and services will be available. The rule says that explicitly. And so we have great fear that some of the most effective and acceptable methods of contraception would simply be eliminated from Title X-funded projects. And that would mean you could come in, perhaps with no idea of what you would like to have as

your method, but want to have a full conversation and be told that certain conversations are not open; this provider is not willing to engage; or those methods aren't available to you.

Ms. CASTOR. Then do you also believe that if this rule is adopted, it likely will lead to more unintended pregnancies?

Ms. COLEMAN. I think that is certainly the case. And I want to draw attention again to the fact that the Federal Government went through a scientific, clear, 4-year process, involving both Government officials and nongovernmental experts. They produced a 50-page report that is available to the public that is based on evidence from ACOG, evidence from the AMA, evidence from the American Cancer Society, evidence from the U.S. Preventive Services Task Force. That is the clinical standard that is in place today and it is designed to be responsive to clients but also to help prevent unintended pregnancy.

Ms. CASTOR. And Ms. Geoffray, we don't have to imagine what the impacts of this shift might be. You say in your testimony, "should this administration be allowed to undermine evidence-based and client-centered services and interfere with the patient-provider relationship in the Title X Family Planning Program, our experience in Texas shows that we risk the loss of qualified providers and, in turn, reduced access to high-quality family planning services in communities across the country."

So based on your experience in Texas, could you go into more detail about the impact of undermining evidence-based care will have on communities?

Ms. GEOFFRAY. Absolutely. As I shared this morning, as a result of the funding and policy changes that happened in Texas in 2011, we saw 82 clinics close, one out of four in our State closed; or reduced hours. Two-thirds of those clinics had no affiliation with abortion service providers and so it was a much larger net than I think was intended to be cast.

We saw clients lose services. Again, after the 2011 cuts, 54 percent of clients lost services. Studies have documented that thoroughly.

I think that we also see that whenever we put overly burdensome requirements or the Government interferes in the patient-provider relationship, that causes providers to disengage from these programs. In Texas, we saw providers who were not willing to sign attestation forms stating that they did not elect—perform elective abortion or affiliate with those who perform elective abortion, simply because they did not believe that it was something the Government should be asking of them and that it might violate their ethics and their duties of care.

Ms. DEGETTE. The gentle lady's time has expired.

Ms. GEOFFRAY. And then also, we saw people not want to sign into a program that didn't allow the coverage of emergency contraception. So again, moving away from evidence-based.

Ms. DEGETTE. The gentle lady's time has expired. Thank you.

The Chair now recognizes the gentle lady from Indiana, Mrs. Brooks.

Mrs. BROOKS. Thank you, Madam Chair.

And I want to thank everybody for a very good discussion about an incredibly difficult subject. And I know we certainly all might

not agree but a couple of things that I want to make sure everybody appreciates is the importance of contraception, the importance of prevention of unplanned pregnancies; and that I think everyone can certainly agree.

I am curious, though, whether or not each of you were here during Dr. Foley's testimony and whether or not you read Dr. Foley's testimony. Ms. Coleman, and did you read her testimony?

Ms. COLEMAN. I was present and I did review the testimony ahead of the hearing.

Mrs. BROOKS. Thank you. Ms. Geoffray?

Ms. GEOFFRAY. Yes, I was present and I read the testimony.

Mrs. BROOKS. OK, thank you. Dr. McLemore?

Dr. MCLEMORE. I was present and I read her testimony.

Mrs. BROOKS. Thank you. Dr. Perritt?

Dr. PERRITT. I was present but I did not read her testimony.

Mrs. BROOKS. OK, thank you. Ms. Foster?

Ms. FOSTER. I was present and read her testimony.

Mrs. BROOKS. And what I have struggled with today is the fact that as a physician, and I am a lawyer, I am not a physician, so I have gone to the Federal Register to try to read what has been written about this rule and I am focused on the nondirective counseling piece that I have struggled with and you heard me ask those questions before.

And that is what I cannot quite reconcile today from what all of the associations and what the organizations that we have all heard about but yet, I am hearing from the top official who oversees the office that oversees these grants. And her testimony, both written, and present today, and backing up this rule, which is the Federal Register rule, 42 CFR Part 59, continues to talk about the fact that nondirective pregnancy counseling does provide and allow for providers to give lists of qualified comprehensive primary healthcare providers which may provide abortion services.

And so I am really struggling with the assertions that that will no longer be allowed under this rule. And I have such tremendous respect for the patient-client—not client—I am the lawyer-client—the physician-patient relationship and yet why would a physician, under this rule, where the rule allows, and the Federal Register allows, and the top doc overseeing this said it is okay, and in fact it is permitted, why would they not be able to provide a list and to have a discussion about abortion when the 13-year-old came in with her mother? Why do you believe that, when she came out very specifically and said that is not what we have written in the rule, that is not how the Federal Register is being interpreted, that is not what we are stating, that is not what she is testifying to under oath?

Why do you believe those discussions cannot happen? Dr. Perritt, whether you have—you heard what she said, whether you read it or not.

Dr. PERRITT. So let——

Mrs. BROOKS. And I respect what you do. I do, I respect what all of you do. And so I am confused why everyone is not listening to what she said.

Dr. PERRITT. Sure, let me offer some clarification. I think Ms. Coleman really spoke to it best when she really stressed the link-

age between counseling and referral. There is something in the medical field called linkage to care. It means that you don't just give someone a piece of paper, say good luck, I wish you well, be on your way, particularly when we are talking about under-resourced communities.

Being trapped in a cycle of poverty is very—it preoccupies you with survival. So what that means is that even disconnecting services and moving them out of the same building is a barrier for people. It is a barrier for the communities that I take care of. So when we offer a list with no context, with no additional information, no realistic avenue to access those services because it is not tied to a referral, that means people cannot get the care that they need. That is not nondirective. That is not patient care. That is not how medicine works.

Mrs. BROOKS. But would you not agree that a provider can have the discussion, even under the rule, and can talk about the pros and the cons but, as I read it, now I am a lawyer so I am trying to read this rule literally and what the CFR literally says, but they can provide counseling and education but the client has to take that active role, and then deciding that information.

So why is that not—so that 13-year-old and her mother, a provider can answer questions, can say here is the list of places that provide all sorts of services, including abortion, according to this, they may provide in addition to comprehensive primary care. That is what is stated here. And that is what I just heard Dr. Foley testify to.

Now it is not in the same building. That is true. This rule does not allow it to be co-located. It does not allow that. But I do not see how the rule does not allow, and I think we have a fundamental disagreement on what I believe Dr. Foley said can happen, and what the rule is stating can happen, and what the community you are representing is saying can happen.

Ms. DEGETTE. The gentle lady's time has expired.

Mrs. BROOKS. And with that, I yield back.

Ms. DEGETTE. The gentle lady from New Hampshire is recognized.

Ms. KUSTER. I would like to pick up right here. Maybe people who have a different life experience might understand these experiences differently. I have been an adoption attorney for 25 years. I have literally represented young birth moms who had, frankly, no idea even how they got pregnant. And for them to be able to direct a conversation with a healthcare provider to ask specifically for options, including terminating the pregnancy I think is beyond the imagination.

I think what we are talking about here is breaching the confidentiality and the sacred nature of the conversation between a healthcare provider and their patient. And for the Government—I believe in less Government interference with people's personal lives. And for the Government to say what that conversation should be is far too much interference.

And I would love, Ms. Coleman, if you would, to give your thoughts on this.

Ms. COLEMAN. I think it is first important to again note that the provider can choose to have no conversations at all in the context

of a family planning visit and in the context of a positive pregnancy test.

Ms. KUSTER. I apologize for interrupting. Can we just clarify for the record? A church can now receive these funds for a program that is solely abstinence or rhythm.

Ms. COLEMAN. If the rule were implemented, and it is not in place today, a church with a health service could participate in a Title X program and provide a single service or a limited range of services.

Ms. KUSTER. So my tax dollars, against my will, going to a church without giving the full range of options that any healthcare provider would provide.

Ms. COLEMAN. I do want to clarify that under today's law, it is permissible under Title X program to have a service site offer a single service. It doesn't happen often but it can happen and it has long been part of the program.

So for example, if a State Health Department wanted to contract with a Catholic University for a university-based health center and that university-based health center said all we want to do is fertility awareness methods, that is permissible under the current Title X program, as long as the other access points in that area, in that project, which may be statewide or may be more limited, offers a broad range of medically-approved methods and services.

So it does allow for diversity of a service mix. The law allows for that now.

Ms. KUSTER. So a 22-year-old student who, because of her own privacy, is not going to pursue a full-blown rape allegation, but was in a situation, in a fraternity basement, that someone took advantage of her, she goes in to this university healthcare and what is she told? She is told that adoption is her option?

Ms. COLEMAN. No, ma'am.

Ms. KUSTER. I mean how does she get any advice?

Ms. COLEMAN. Under the current rules, upon a patient's request, you provide full options counseling. So if a patient comes in and either knows she is already pregnant or you confirm pregnancy at the visit, it is led by the patient. So, I often say if the patient says I am thrilled, you don't say let me talk to you about giving up your child for adoption or abortion. You respond to the client that is in front of you.

Ms. KUSTER. Right but I am saying she is distressed. She doesn't remember anything. She was given a Rohypnol pill and she finds herself pregnant. She does not want to be pregnant. She wants to continue her studies and carry on with her life. And in that case of the religious school with the sole source, they would say oh——

Ms. COLEMAN. Let's separate the offering of the methods from the requirements to do full comprehensive options counseling upon the patient's request. Those are different.

So that patient could come, they could offer one method of contraception but, if the patient had a positive pregnancy test, was in deep distress, and asked for information about a single option, termination, or all three options because she needed time to think about it, the organization in Title X today would be required to furnish her with nondirective medically-accurate, neutral information, and referral upon request.

Ms. KUSTER. How about after the rule, if this rule goes into effect?

Ms. COLEMAN. After the rule, neither the counseling nor referral for—well, referral for abortion wholly prohibited. Directive prenatal referral required.

So if she was in distress and just said I need some time to talk about it, under this rule, you wouldn't give her time. You would see, here is a prenatal care referral but you could skip all the discussion and the rule doesn't require that your counseling be medically accurate.

Ms. KUSTER. I am out of time.

Ms. DEGETTE. The gentle lady's time has expired.

Ms. KUSTER. I had some great questions that I will refer to the record. Thank you.

Ms. DEGETTE. The gentleman from Oklahoma is recognized for five minutes.

Mr. MULLIN. Thank you, Madam Chair, and thank you for the panel that stayed.

I am going to ask some tough questions but it is really not an 'I got you' question, Dr. Perritt, because most of them are going to be coming to you. It is not an 'I got you' question. It is about information. You were very precise on answering some questions a while ago, where you said it is about the context, and the information to your patient, and providing them with their best choices but part of that is actually understanding what those options are, and what those options include.

So with that being said, you are an OB/GYN, right?

Dr. PERRITT. I am.

Mr. MULLIN. And you have delivered babies and you have also performed abortions or you currently still perform abortions. Is that correct?

Dr. PERRITT. Yes.

Mr. MULLIN. What is the latest stage that you have performed an abortion?

Dr. PERRITT. So I would love to talk with you a little bit about what is happening with my patients but my medical practice right now is not what I came here to discuss.

Mr. MULLIN. I know.

Dr. PERRITT. We have a lot of time——

Mr. MULLIN. No, no, this is about—no, no, this is about information. I am asking questions.

Dr. PERRITT. Information that is relevant to Title X?

Mr. MULLIN. Yes, it is because it is about information to which we are talking about here. If we are going to have these options out to the public, then they also got to know what their choices are. This is what you are saying, that you want to provide your patient with the best information possible. And you are saying that under Title X, underneath the new rule, that that will be prohibited for you to do so but yet, we have had this discussion back and forth saying it wouldn't be.

So let's talk about the information. You have performed abortions, correct?

Dr. PERRITT. I have already said that I do.

Mr. MULLIN. OK, so how many babies have you delivered?

Dr. PERRITT. I don't know the answer to that and once, again——
Mr. MULLIN. Just roughly. Just roughly.
Dr. PERRITT [continuing]. We are here talking about—I don't know the answer to that.
Mr. MULLIN. OK, so how many abortions have you performed?
Dr. PERRITT. What I—and I don't know the answer to that.
Mr. MULLIN. You don't?
Dr. PERRITT. What I would like to talk with you about——
Mr. MULLIN. No, ma'am, I am asking the questions.
Dr. PERRITT. Sure.
Mr. MULLIN. I am asking the questions here.
Can you tell me then what the difference is between a baby being delivered and performing an abortion?
Dr. PERRITT. I can tell you the difference between taking care of low-income people——
Mr. MULLIN. No.
Dr. PERRITT [continuing]. Who need access to reproductive services——
Mr. MULLIN. That is not my question that I am asking you.
You want to provide information to the patient but for some reason, you don't want to talk about the abortion, what procedures take place.
My question to you is: What is the difference? When you are delivering a baby or you are performing an abortion, what is the difference?
Dr. PERRITT. What I would like——
Ms. DEGETTE. So I am going to stop this right now. And the reason I am going to stop it is because the rules of the House say that we have the responsibility to preserve order and decorum.
Mr. MULLIN. And so where am I out of order on this?
Ms. DEGETTE. Let me finish. The title of this hearing is on the Protecting Title X and Safe-Guarding Quality Family Planning Care. And it is completely outside the——
Mr. MULLIN. Abortion has been brought up multiple times in this hearing.
Ms. DEGETTE. Excuse me. The gentleman will come to order. It is outside the purview of this——
Mr. MULLIN. No, it is outside the purview because you guys don't want to talk about it. And yet anybody else on that side can bring up whatever they want to, and they can talk about whatever they want to. But when I am asking a question——
Ms. DEGETTE. The gentleman will yield back.
Mr. MULLIN [continuing]. And I said it is very clear, I am not trying to I got you, it is trying to be information that all of a sudden you don't want to talk about it.
Ms. DEGETTE. The gentleman will suspend and the Chair will explain.
The title of this hearing is on Protecting Title X and Safe-Guarding Quality Family Planning care. It is not on the nature of Dr. Perritt's personal medical services.
Mr. MULLIN. It is about information that needs to be given out.
Ms. DEGETTE [continuing]. And if the gentleman wishes to ask about the topic of this hearing, he is more than welcome to, as have——

Mr. MULLIN. The topic has been about abortions the whole time. Everybody has been talking about the abortions. Yet, when I want to discuss it because I want to talk about the procedures that want to be done, now all of a sudden we can't talk about it?

Ms. DEGETTE. The gentleman may proceed to talk about the topic of this hearing.

Mr. MULLIN. So then tell me what the topic is, I guess, because I have been hearing you guys talk about everything underneath the sun but yet we can't talk about abortion now that I want to? Because you guys are.

No, seriously, where is the line? Because I don't know where the line is anymore.

Ms. DEGETTE. As the Chair has noted, questions to the witnesses, the physician and—the medical witnesses about the character of their——

Mr. MULLIN. She is here talking about her profession, that she is an OB/GYN——

Ms. DEGETTE. The gentleman has an answer to that question.

Mr. MULLIN [continuing]. And she is testifying on that behalf about her patient and providing her patient information. If they are talking about information, then the procedure of how that abortion is performed should be part of the information that the patient receives.

Ms. DEGETTE. Sir——

Mr. MULLIN. Is that not accurate?

Ms. DEGETTE [continuing]. You are attacking the witness——

Mr. MULLIN. I am not attacking.

Ms. DEGETTE [continuing]. On her personal medical—her medical practice.

Mr. MULLIN. How am I attacking? I am asking questions.

Ms. DEGETTE. She has a——

Mr. MULLIN. Tell me one thing that has been a personal attack.

Ms. DEGETTE. The gentleman is out of order. He can ask questions about the topic of this hearing.

Mr. MULLIN. That is the topic of the hearing.

Ms. DEGETTE. You may proceed.

Mr. MULLIN. On the discussion that I was saying?

Still wanting to know what the difference between performing an abortion and delivering a baby is.

Dr. PERRITT. As I mentioned before, I am happy to talk with you about the patients that I take care of and——

Mr. MULLIN. Ma'am, you are here as a professional testifying. And I am asking an information question that I am not attacking you personally on. I am simply wanting to know what the difference is.

Dr. PERRITT. Whether or not——

Mr. MULLIN. I think it is important for the public to know because you are talking about choice. You are talking about understanding the differences and providing your patient with the information. This is prevalent, too.

Dr. PERRITT. My concern is not whether or not you are attacking me personally.

Mr. MULLIN. I am not.

Dr. PERRITT. I am not here as a personal individual. I came here only to talk about——

Mr. MULLIN. OK, then answer my question.

Dr. PERRITT. I came to talk about the people that I take care of.

Mr. MULLIN. And this is part of it.

Dr. PERRITT. We are talking a lot about——

Mr. MULLIN. This is part of it.

Dr. PERRITT. We are talking a lot about providers, the care that I provide inside the office, and what Planned Parenthood does.

Mr. MULLIN. What——

Dr. PERRITT. There is not one single person here, other than the medical providers who are talking about the people that are impacted, the patients. That is why I am sitting here.

Mr. MULLIN. This is talking about the patient. The patient needs to know the information. So what is the difference between delivering a baby and performing an abortion? Ma'am, you have done both. You are the best person to ask this question to.

Dr. PERRITT. I am the best person to talk about——

Mr. MULLIN. Then answer it.

Dr. PERRITT [continuing]. What happens in the office when individuals don't have the care that they need. I am the best person to talk about what it means to——

Mr. MULLIN. Then why won't you answer this question?

Dr. PERRITT [continuing]. Be in an urban place, or a rural place and not be——

Mr. MULLIN. Why are you avoiding the question?

Dr. PERRITT. I am not avoiding any question.

Mr. MULLIN. Ma'am, you are, too, because I have asked it to you three times——

Dr. PERRITT. I am trying to—I would love to——

Mr. MULLIN [continuing]. And you just won't answer it.

Dr. PERRITT [continuing]. Talk about family planning services and reproductive healthcare in the context of Title X.

Mr. MULLIN. OK, ma'am, obviously you don't want to talk about it. You want to provide every option but you don't want to get into the details.

Do you think those details are important that your patient should receive those details when you are making a referral for them to go get an abortion? Do you think you should give that information to your patient to tell them what it is going to entail, that how you are going to kill that baby is going to take place, how the abortion is going to be performed, and then what the difference is? You don't think that information is prevalent?

Dr. PERRITT. What I think is that your rhetoric is inflammatory.

Mr. MULLIN. Rhetoric?

Dr. PERRITT. It is not medically-based——

Mr. MULLIN. It's not medically-based?

Dr. PERRITT. [continuing]. And it is absolutely offensive because you suggest——

Mr. MULLIN. Do you end the life of the fetus?

Dr. PERRITT [continuing]. That neither or I nor my patients know what they are there to talk about or what care that they need.

Mr. MULLIN. Do you end the life of the fetus?

Ma'am, there is no way that I am out of time because you and I had a discussion for a minute and a half.

Ms. DEGETTE. We stopped the clock.

Mr. MULLIN. I watched it run.

Ms. DEGETTE. We stopped the clock.

The Chair will now recognize the gentleman from New York, Mr. Tonko, for five minutes.

Mr. TONKO. Thank you, Madam Chairwoman.

We have heard today just how pivotal the role of Title X has played over the past 50 years in building a network of family planning clinics that ensure access to high-quality reproductive care, for low-income, or uninsured individuals, many of whom face barriers to care.

We have also heard today from Dr. Foley that provisions within the Trump administration's new Title X rule were, and I quote, "designed to increase the number of clients served within the Title X programs." In fact, Dr. Foley also contends that the rule, and I again, "focuses on innovative approaches to expand Title X services and make inroads into sparsely population areas."

So Ms. Geoffray—do I have that correct—let me being with you, since the Title X network you manage in Texas presumably spans some sparsely populated areas.

Do you believe the provisions in the rule would lead to an increase in the number of Title X clients served?

Ms. GEOFFRAY. I think that the provisions of the rule, as they are—if they would be implemented, would allow providers that do not provide comprehensive family planning care that is evidence-based and client-centered to enter our network. And while clients may be served by those providers, we have serious concerns about the types of services they would receive.

I also have concerns that those most qualified providers, those who are providing evidence-based client-centered care, would be disincentivized from continuing their participation in the program, if these rules went into effect, specifically as it relates to options counseling and what they could and could not say in the context of those counseling sessions.

Mr. TONKO. And similarly, Ms. Geoffray, I am curious as to whether you would characterize the rule as focusing on what they call innovative approaches to expand Title X services.

Ms. GEOFFRAY. I do not. I would like to speak a bit about the innovations that the current grantees, including what we are doing in Texas, what we are doing now, if that is OK with you.

Mr. TONKO. Sure.

Ms. GEOFFRAY. So many of our counterparts around the country are working to integrate substance use disorder treatment into the family planning care that we provide. We are using telemedicine and telehealth to deliver family planning services to remote and rural locations. We are providing outreach in culturally-competent ways across different communities, across the country, to ensure that people are accessing much-needed care. We are working in school-based health centers to help teens understand their sexual and reproductive health needs and how to access services.

So I would say that we are doing a lot of very innovative care across the country right now. If what the rule promotes is in-

creased access to one method of care, specifically fertility awareness-based methods, I would not call that innovation. I would actually call that something that our providers are doing in the context of the broad range of family planning care right now.

Mr. TONKO. Thank you.

And Ms. Coleman, you have heard the answers that we received here from Ms. Geoffray. Are there reasons to be concerned that the administration's rule may in fact result in the opposite outcomes, should it be implemented?

Ms. COLEMAN. Certainly. So there have been a number of State Governments and a number of provider entities that have stated publicly that they would not be able to continue to participate in Title X-funded care if this rule were implemented. There are many, many places in the country where the provider network is dominated by one kind of provider, whether they be local health departments, for example, in a State like South Carolina or Montana. And so we have great concerns that there may be wholesale withdrawals or just withdrawals in certain parts of a State and that would certainly impact access to care.

I will say something that I said earlier, which is Title X-provided services are in 60 percent of U.S. counties but that is where 90 percent of women in need live. And so when the administration persists in saying there are underserved areas, there are underserved areas, there is no conversation happening with our grantees, at this stage, about where those last ten percent of women in need, and I want to recognize that there are more than just women who require family planning and sexual health services under Title X, but there is no discussion with this network about how we might meet that last bit of need that is not being attended to by a provider site right now.

Mr. TONKO. Thank you. Well, I am curious, Ms. Coleman. If we were in fact committed to increasing the number of patients to Title X program services they could access, even in remote areas, what would Congress and the administration be doing to realize these goals?

Ms. COLEMAN. I am pleased you asked that question. NFPRHA came to the Hill this year and asked for $737 million, which is derived from a 2016 Health Affairs research study that was a CDC Office of Population Affairs and George Washington University researchers collaborated. And they said with Medicaid expansion, and with the Affordable Care Act somewhat in place, they made certain assumptions, that we would need $737 million annually appropriated to Title X just to meet the needs of women.

I just want to remark that under our last set of data, about 12 percent of the people we see are men in Title X. So we probably need more than $737 million a year but that would go a long way to meeting the needs of low-income women in this country.

Mr. TONKO. Well, I thank all of you for testifying today.

And with that, I yield back.

Ms. DEGETTE. The gentleman yields back. The Chair now recognizes Mr. Bilirakis for five minutes.

Mr. BILIRAKIS. Thank you, Madam Chair. I appreciate it so much. Thank you for your testimony today and thanks for allowing

me to sit in. I am not on this subcommittee, so I really appreciate you allowing me to sit in.

Ms. Foster, historically, there have been a limited competition among Title X grantees. In 2009, the Institute of Medicine, now the National Academies Press, issued a report noting that, and I quote, "competition rarely occurs among grantees in the program, since there are few applications for any given award, and there is almost no guaranteed turnover, less than two percent per year, according to the Institute." Since at least fiscal year 2010, HHS' congressional budget justification has commonly emphasized the importance of competition and noted the program's desire to, and I quote, "to increase competition for family planning services—service funds.'

So the question is, Why is it important to have competition in the Title X program among grant recipients? Does competition make for a healthier Title X program?

Ms. FOSTER. Absolutely. Competition will make for a healthier Title X program. It will increase the diversity among the program grantees. It will allow for a broader range of grantees, of organizations, of clinics, of services, to include the full range of family planning services. And I believe that it will make the entire program better, that everyone will rise to the challenge.

We know that, for example, when it comes to family planning Federal funding more broadly, things like Medicaid and so on, we know that there is evidence of family planning clinics billing for abortion-related services. We know that from Georgia, from Maine, from Nebraska, from New York, over and over, and over, Massachusetts, Washington State. And Maine called one instance a clear violation. We know that one New York audit found that 42 percent of a sample of billing instances were improperly billed as—they were abortion services, abortion-related services and 42 of the sample was improperly billed to the Federal Government as abortion services, when it should not have been.

So it will work to ensure that that sort of misbilling, of waste, and abuse, and improper commingling will not take place; and that we will increase the diversity within the program.

Mr. BILIRAKIS. So what steps are HHS taking to increase competition and diversity in the Title X—for Title X grantees?

Ms. FOSTER. Well this rule is about transparency, and consistency, and accountability. It is not new. The requirement about nondirective counseling is not new. And as we discussed earlier, *Rust* v. *Sullivan* even upheld a stricter construction of counseling.

So if Congress disagrees with the Title X requirements supported by this rule, Congress is free to readdress the Title X requirements. But in the meantime, this rule supports those requirements and even works to increase diversity, to increase the range of providers who will be in the marketplace for women.

Mr. BILIRAKIS. Okay and that includes ideological diversity; if so, why is it important? Why is that an important measure for diversity under the Title X program?

And then also, I have one last question. Does it also include geographical diversity and, if so, why is that important that we have geographical diversity as well?

Ms. FOSTER. Ideological and geographical diversity are both critical to the Title X program. Low-income women, immigrant women deserve to be able to access providers who match their backgrounds, who match their—whether it is a faith background; or some other background, they should be able to access the services that they desire from the provider that they desire.

And in the past, we have had issues where, for example, we had Title X requirements that went against the Weldon Amendment, for example, and would have required referrals against the conscience rights of healthcare providers. This prevents that and ensures that a broader range of providers, who are offering a broad range of services, many of them may be offering services that include things like hormonal contraception, that include a full range of family planning services, but are more ideologically aligned to the women. And by increasing the number of providers in the marketplace, we would hope to be able to see a greater geographical diversity as well and more clinics in women's own neighborhoods, in their backyards, so that they are able to easily access.

Mr. BILIRAKIS. All right, thank you very much.

I yield back, Madam Chair.

Ms. DEGETTE. The gentleman's time has expired.

Welcome to Mrs. Rodgers from Washington State. We are glad you are here. We recognize you for five minutes.

Mrs. RODGERS. Thank you Madam Chair, Ranking Member, and thank you everyone for being here today.

Title X of the Public Health Service Act provides family planning services to low-income women. Today, there are approximately 4,000 Title X service sites in the United States, including State and county health departments, Community Health Centers, non-profit clinics, and Planned Parenthoods.

The Protect Life Rule ensures that taxpayer-funded family planning centers will serve their intended purpose, to help women receive comprehensive, preventative healthcare, while ensuring the separation of taxpayer funds from abortion services.

Ms. Foster, I have a couple of questions for you. First, how do these centers that are eligible for Title X funding under the Protect Life Rule provide comprehensive and primary care to women?

Ms. FOSTER. Centers that will be eligible under the Protect Life Rule will be able to provide the range of family planning services. Thanks to pooling, not every center may provide a full range, that is true, but within a geographical area, the full range of family planning services will be provided.

Mrs. RODGERS. If abortions only make up a small percentage of services offered by Planned Parenthood, it should be no problem for them to comply with this rule. If they or organizations similar to them were willing to comply with these simple rules, would they continue to receive funding?

Ms. FOSTER. Any organization that complies with the rule which, again, supports Title X as enacted by Congress, will be eligible to continue to receiving funding.

Mrs. RODGERS. So if they choose to prioritize abortion over preventative women's healthcare, they would be denying their own access to this funding.

Ms. FOSTER. I would consider that to be detrimental to women and girls.

Mrs. RODGERS. Who will fill the gap if Planned Parenthood refuses to comply with the Protect Life Rule?

Ms. FOSTER. We know that there are many organizations in the marketplace. Of course we don't know exactly how it will impact the market because we don't know who will enter the market, who may leave the market, and to whom HHS will award grants but we are confident that the market can accommodate this change between Community Health Centers, Federally Qualified Health Centers, and the range of providers that have expressed interest and are applying and in some cases have been denied, like Obria Group, but would be eligible under the Protect Life Rule to receive Title X funding for family planning services.

Mrs. RODGERS. Out of 4,000 Title X sites, less than 500 are Planned Parenthoods. In my district alone, there are 26 Federally Qualified Health Care Centers, the FQHCs, compared to four Planned Parenthoods. So this change would only allow for an expansion of coverage to more locations, including all of those 26 FQHCs that don't offer abortions, as well as allowing faith-based family planning centers to apply for grants without slashing access to women's healthcare. By opening the process and allowing for religious protections, this will actually expand preventative healthcare services for more providers to receive funding and provide additional preventative healthcare to low-income communities.

Thank you, Madam Chair, for allowing me to join you today and I yield back.

Ms. DEGETTE. Thank you so much for coming, Mrs. Rodgers. I appreciate it.

Mr. Guthrie doesn't have anything further. So I just have a couple of questions, and a comment, and then some document requests.

Ms. Foster said that programs are billing for—Title X programs are billing for abortion services. And Dr. Foley, in her testimony, said that she was unable to present any evidence of that. And of course, if Title X programs were billing for abortion, that would be illegal.

So Ms. Coleman, I am just wondering if briefly you can let me know if that is happening, if you know whether that is happening, and just clarify.

Ms. COLEMAN. There is no evidence or data to indicate that any Title X funds are being used to subsidize abortion care.

When the proposed rule came out last year, the administration made a contention that Medicaid funds, subject to OIG audit, had been found with some discrepancies in abortion billing. That is completely separate from the Title X program and there has been no implication that Title X entities or Title X funds are implicated. And the reason why we know the administration agrees with that is when they put out the final rule, they withdrew the portions about the Medicaid billing issues and said we recognize that these are not the same.

Ms. DEGETTE. Thank you very much.

And I just want to close by clarifying. I think there has been a little confusion today and I think we need to be really clear what we are talking about.

The first thing is I want to thank all of the witnesses for coming today, all five of you, and presenting your perspectives. I also want to apologize for some of the badgering that you have had to encounter but this is a tough issue, and I am proud of you for the answers and for standing up.

Here is what we are dealing with. The law that we have all been talking about says none of the funds appropriated under this Title shall be used in programs where abortion is a method of family planning. Ever since the statute was passed in 1970, organizations that provide abortion services do not receive Title X funding for family planning. And they keep it completely separate. And as we have heard, the evidence is that organizations that perform abortions do not get the Title X money.

The confusion is around counseling, pregnancy counseling and what that means. And as has been discussed, there was a court decision, the Rust decision, where the question was did Congress mean organizations that provide counseling for abortion services and other types of services or does it mean the abortion services themselves. And the court in the Rust decision said Congress needs to give direction as to what it means, if the statute was intended to not fund abortion or abortion counseling.

So in 1996, Congress passed a law and it said all pregnancy counseling shall be nondirective. What that has meant, for over 20 years, since 1996, is that providers are required to give nondirective counseling and they have been given scientific nondirective counseling to patients which, as the doctors on our panel and the nurses testified, is so important for patient health and safety.

So that is what this new rule that HHS has tried to promulgate violates. What it says is we can give Title X money to organizations that will not—where the organization will not provide the patient with the full range of healthcare information that they need, even if the patient requests it. That is why Dr. Perritt, and Dr. McLemore, and others have pointed out that this interferes with the patient-doctor relationship.

And it is also against public policy to try to prevent unwanted pregnancies. This is what just amazes me. If we want to prevent unwanted pregnancies, if want to prevent increases in abortion, or in unwanted children being born, then we should have robust family planning programs that are evidence-based, that are targeted at the patient, and that the doctor and patient can talk about. And that is why Title X has been so effective and that is why we need to keep it.

And also, P.S., that is why the court has enjoined the enactment of this rule because it violates the ethics of medicine.

And so I know this was a tough discussion today; and it is always a tough discussion but I am going to say what I always say on the floor when we have these bills, if we really want to prevent unwanted pregnancies and reduce abortion, I think we should all work together on both sides of the aisle to pass robust birth control legislation, including long-acting birth control, which is wildly successful in my State and all around the country.

So thanks again, everybody, for coming.

I would ask unanimous consent to put the following documents into the record, and the minority has seen them: a letter from the AMA opposed to this regulation dated June 18, 2009; a letter from the American College of Obstetricians and Gynecologists dated July 31, 2018; an article entitled The Final Title X Regulation Disregards Expert Opinion and Evidence-Based Practices dated February 26, 2019; a letter from the American Public Health Association dated July 30, 2018 opposing the regulation; a letter from the American Academy of Pediatrics—did I do that one already—dated July 31, 2018; and a letter from the AMA dated July 31, 2018.

Without objection, so ordered.

Ms. DEGETTE. Again, I want to thank all the witnesses and thank you for waiting for us.

This hearing is adjourned.

[Whereupon, at 4:41 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

June 19, 2019

Representative Michael Burgess, MD
Ranking Member
Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
2322 Rayburn House Office Building
Washington, DC 20515

Dear Dr. Burgess,

I would like to draw your attention data showing overall positive trends in Texas including a reduction in the number of abortions year after year.

Between 2011 and 2015, the last year for which data is publicly available, the minor pregnancy rate in Texas fell by 39 percent, the minor birth rate fell by 36 percent, and the minor abortion rate fell by 53 percent. Additionally, during this time the overall abortion rate in Texas declined by over 29 percent and the state birth rate exhibited little change.

Please see the attached chart for notable statistics made publicly available by the Texas Department of State Health Services at https://www.dshs.state.tx.us/chs/vstat/annrpts.shtm.

Sincerely,

Michael J. New Ph.D.
Associate Scholar, Charlotte Lozier Institute
Visiting Assistant Professor, The Catholic University of America

	2011	2012	2013	2014	2015
Pregnancy Rate, 15-44	82.9	82.1	81.1	80.4	79.9
Pregnancies, 15-44	447,575	448,833	449,523	454,001	458,338
Live Births, 15-44	376,185	381,315	385,949	398,369	402,275
Abortions, 15-44	69,354	65,534	61,513	53,484	53,934
Female Population 15-44	5,396,955	5,464,147	5,545,528	5,646,735	5,736,537
Pregnancy Rate, 13-17	19.4	17.2	15.2	13.1	11.8
Pregnancies, 13-17	17,825	16,049	14,464	12,837	11,798
Live Births, 13-17	14,630	13,469	12,234	11,098	10,148
Abortions, 13-17	3,107	2,522	2,163	1,658	1,585
Female Population, 13-17	920,525	933,656	954,592	980,083	1,000,801

https://www.dshs.state.tx.us/chs/vstat/annrpts.shtm.

American Academy of Pediatrics

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SAHM
SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE

July 31, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: HHS-OS-2018-0008; Compliance with Statutory Program Integrity Requirements

Dear Secretary Azar:

The American Academy of Pediatrics and the Society for Adolescent Health and Medicine write in response to the proposed rule, "Compliance with Statutory Program Integrity Requirements" (Proposed Rule), published in the Federal Register on June 1, 2018 by the Department of Health and Human Services (HHS). The Proposed Rule would fundamentally alter the Title X Family Planning Program (Title X), and put at risk nearly 50 years of progress in public health.

The American of Pediatrics (AAP) is a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Reproductive health care is a necessary component of overall health care for adolescents and young adults, and the AAP is committed to ensuring access to this care, including family planning services, sexual health screenings, and contraception. Pediatricians believe that the Title X Family Planning Program is critical to the goal of securing access to these services for this population, providing low-cost or no-cost access to reproductive health care for adolescents and low-income young adults and ensuring that cost and confidentiality are not barriers to care for this population. The AAP believes that Title X has been of enormous benefit to this population for over four decades.

The Society for Adolescent Health and Medicine (SAHM) is a multidisciplinary organization that promotes optimal health, well-being, and equity for all adolescents and young adults by supporting adolescent health and medicine professionals through the advancement of clinical practice, care delivery, research, advocacy, and professional development. SAHM is keenly aware of the vital role the Title X Family Planning Program has played in making sure that adolescents and young adults, especially those with low incomes, are able to receive the full spectrum of family planning services, including contraception and other services such as testing and treatment for sexually transmitted infections (STIs) and cancer screening that are essential to protecting their health.

The Proposed Rule undermines the patient-provider relationship. Contrary to the preamble of the Proposed Rule, which states that "the new regulations would contribute to more clients being served, gaps in service being closed, and improved client care that better focuses on the family planning mission

of the Title X program,"[1] the proposed changes to the program would jeopardize access to family planning and preventive health care for more than four million low-income women, men, and adolescents, and put at risk patient access to high-quality care. We therefore call for the Proposed Rule's immediate and complete withdrawal.

I. The Title X Family Planning Program plays a critical role in our nation's public health safety net.

As the only federal grant program dedicated exclusively to providing low-income patients with essential family planning and preventive health services and information, Title X plays a vital role in ensuring that safe, timely, and evidence-based care is available to women, men, and adolescents, regardless of their financial circumstances. Rates of adverse reproductive health outcomes are higher among low-income women and women of color, and unintended pregnancy rates are highest among those least able to afford contraception.[2] According to the HHS Office of Population Affairs website, "Access to quality family planning and reproductive health services is integral to overall good health for both men and women. Few health services are used as universally. In fact, more than 99 percent of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method."[3]

In addition to pregnancy prevention, Title X projects meet other reproductive health needs. In 2016, Title X projects provided nearly five million STI tests, more than 700,000 Pap tests, and 900,000 clinical breast exams.[4] Further, it is estimated that in 2010 alone, services provided by Title X projects helped avert 53,450 chlamydia infections, 8,810 gonorrhea infections, 250 HIV infections, and 6,920 cases of pelvic inflammatory disease.[5]

Unintended pregnancy and STIs are of particular concern for adolescents and young adults. Among 15-19 year-olds, three quarters of pregnancies are unintended as are nearly 60 percent of pregnancies among 20-24 year-olds.[6] Teen-aged birth rates in the United States have declined to the lowest rates seen in seven decades yet still rank highest among industrialized countries.[7] Research suggests that the decline is largely due to increased use of contraception.[8] Youth are also disproportionately impacted by STIs. Data from the Centers for Disease Control and Prevention indicate that adolescents and young

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[1] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25505.
[2] Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:250–5.
[3] Family Planning Guidelines. Office of Population Affairs. Department of Health and Human Services. https://www.hhs.gov/opa/guidelines/program-guidelines/index.html
[4] Fowler CI, Gable J, Wang J, Lasater B. Family Planning Annual Report: 2016 national summary. Research Triangle Park, NC: RTI International (August 2017). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf
[5] Sonfield A. Beyond Preventing Unplanned Pregnancy: The Broader Benefits of Publicly Funded Family Planning Services. Guttmacher Policy Review 17, issue 4 (2014). https://www.guttmacher.org/sites/default/files/article_files/gpr170402.pdf.
[6] Finer LB, Zolna MR. Declines in Unintended Pregnancy in the United States, 2008-2011. N Eng J Med 2016 Mar 3;374(9):843-52. doi: 10.1056/NEJMsa1506575.
[7] Santelli JS, Song X, Garbers S, Sharma V, Viner RM. Global Trends in Adolescent Fertility, 1990-2012, in Relation to National Wealth, Income Inequalities, and Educational Expenditures. J Adolesc Health 2017 Feb;60(2):161-168. doi: 10.1016/j.jadohealth.2016.08.026. Epub 2016 Nov 15.
[8] Lindberg L, Santelli J, Desai S. Understanding the Decline in Adolescent Fertility in the United States, 2007-2012. J Adolesc Health 2016 Nov;59(5):577-583. doi: 10.1016/j.jadohealth.2016.06.024. Epub 2016 Aug 29.

adults account for half of all STI diagnoses in the United States despite only making up a quarter of the sexually active population.[9] Sixty-five percent of reported chlamydia and 50 percent of reported gonorrhea cases occur among 15-24 year-olds.[10] Untreated STIs can lead to long-term reproductive health consequences. Pregnancy and birth are significant contributors to high school dropout rates among female youth; only approximately 50 percent of teen-aged mothers earn a high school diploma by 22 years of age versus approximately 90 percent of females who did not give birth during adolescence.[11] Title X not only improves the health and lives of women and their families and enables them to achieve greater educational, financial, and professional success and stability. It also saves taxpayer dollars. Taxpayers save an estimated $7.09 for every dollar invested in the Title X program.[12]

If implemented, the Proposed Rule would limit access to vital preventive services for the more than four million patients seeking care annually at a Title X project, including many adolescents and young adults, increasing rates of unplanned pregnancy and other adverse sexual and reproductive health outcomes, undermining public health and turning back the clock on women's health.

II. The Proposed Rule would interfere with the patient-provider relationship and restrict the information available to patients.

The provision of safe and quality medical care relies on a strong patient-provider relationship free from political interference. Patients expect medically accurate, comprehensive information from their providers; this dialogue is imperative to the integrity of the patient-provider relationship. If implemented, the Proposed Rule would drive a wedge between patients and their providers by placing restrictions on the counseling and referrals that can be provided to patients, in some instances directing providers to withhold information critical to patient decision-making.

Specifically, the Proposed Rule removes requirements that patients be offered nondirective counseling on the full range of reproductive health options, instead placing vague and confusing restrictions on the counseling that can be provided to patients.[13] In addition, the Proposed Rule directs providers to withhold full and accurate information and to include referrals to providers that do not offer the service requested by the patient.[14] For example, the Proposed Rule requires that even those patients who specifically state their intention to obtain an abortion must be given a list of referrals that includes providers who do not offer abortions and that does not identify those who do, stating: "The list shall not identify the providers who perform abortion as such."[15] This obstacle to nondirective options counseling conflicts with medical practice guidelines, including those of the American Academy of Pediatrics.[16] The

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[9] Centers for Disease Control and Prevention. STDs in Adolescents and Young Adults. https://www.cdc.gov/std/stats16/adolescents.htm.
[10] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2015. Atlanta, GA:US Department of Health and Human Services; 2016. www.cdc.gov/std/stats15/default.htm.
[11] Perper K, Peterson K, Manlove J. Diploma Attainment Among Teen Mothers. Fact Sheet. Publication #2010-01. Washington, DC: Child Trends; 2010.
[12] Frost JJ et al., Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program. Milbank Quarterly 2014 Dec;92(4):696–749. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4266172/.
[13] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25530.
[14] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25531.
[15] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25531.
[16] Hornberger LL and AAP Committee on Adolescence. Diagnosis of Pregnancy and Providing Options Counseling for the Adolescent Patient. Pediatrics 2017 Dec 140(3):e20172273.

Proposed Rule would also require Title X providers to refer all pregnant patients to "appropriate prenatal and/or social services (such as prenatal care and delivery, infant care, foster care, or adoption)"[17] even if the patient has indicated a clear decision to terminate her pregnancy.

Access to medically accurate, comprehensive guidance based on a clinician's expertise, experience, and best judgment is of particular importance for adolescents, and interference in the relationship between a provider and an adolescent patient is highly concerning. Adolescents may experience heightened obstetric risk as compared with women who experience pregnancy at a later age.[18] Several studies have found that adolescents are at a higher risk of complications, such as preterm delivery, small-for-gestational-age infants, and neonatal death, though the evidence is inconclusive. However, the psychosocial risks associated with adolescent parenting are well-established, including a lower likelihood of adolescent mothers receiving a high school diploma, an increased chance of living in poverty during adulthood, poorer academic performance and increased likelihood of dropping out of high school among children of adolescent mothers, and increased risk for daughters of adolescent mothers to become adolescent mothers themselves.[19] Given the weight of the evidence and the serious implications of adolescent pregnancy and parenthood, it is critical that health care providers be able to engage in open dialogue around the health risks and potential outcomes of adolescent pregnancy.

Moreover, the restrictions on counseling and referral information that can be shared by Title X providers may put them at increased risk of medical liability. The decision in the case of *Wickline v. State of California* found that "it is no defense in a medical liability case to argue that physicians simply have followed a payer's instructions."[20] By restricting the provision of clear, direct referrals to patients, the patient is faced with unnecessary barriers and delayed access to care, putting the patient at risk of undiagnosed medical conditions, and placing Title X providers at elevated risk of liability.

Efforts to regulate the way in which Title X providers talk to their patients are inappropriate and prevent access to complete and accurate medical information necessary to ensure that patients are able to make timely, fully informed medical decisions. We reject this intrusion into the patient-provider relationship.

III. The Proposed Rule threatens patient confidentiality, will cause harm to patients, and will lead patients to avoid seeking care.

Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Patients seeking family planning services encompass a broad spectrum of patient populations.[21] Certain groups, including adolescents and young adults and people at risk of domestic or intimate partner violence, have special privacy concerns that

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[17] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25531.
[18] Hornberger LL and AAP Committee on Adolescence. Options Counseling for the Pregnant Adolescent Patient. Pediatrics. 2017;140(3):e20172274.
[19] Hornberger LL and AAP Committee on Adolescence. Options Counseling for the Pregnant Adolescent Patient. Pediatrics. 2017;140(3):e20172274.
[20] Rosenbaum S et al. The Title X Family Planning Proposed Rule: What's at Stake for Community Health Centers? Health Affairs Blog, June 25, 2018.DOI: 10.1377/hblog20180621.675764.
[21] Gold RB. A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents. Guttmacher Policy Review 2013; 16(4):2. https://www.guttmacher.org/pubs/gpr/16/4/gpr160402.pdf.

require particularly strong protection.[22] The Title X confidentiality regulations[23] are among the strongest in current law, and research shows these confidentiality protections are one of the reasons individuals choose to seek care at Title X sites.[24] The current regulations contain exceptions that allow health providers to disclose patient information without documented consent only if necessary to provide services to the patient or if the disclosure is required by law; but even then appropriate safeguards for confidentiality must be in place.[25]

The need for Title X's strong confidentiality protections is supported by both research and medical practice standards. Of particular relevance, the Title X confidentiality protections are grounded in research about the effect of confidentiality on patients' health care access. Decades of research findings have shown that privacy concerns influence the behavior of patients, particularly adolescents and young adults, with respect to whether they seek care, where they do so, which services they accept, and how candid they are with their health care providers.[26] Adolescents are especially concerned about disclosures to their parents of their use of family planning services: numerous studies demonstrate that requiring parental notification would drive minors out of family planning clinics and away from critical health care including contraception and testing and treatment for STIs. [27]

Cognizant of the key role confidentiality plays in access to health care and in the provision of high quality health care services, numerous medical organizations have issued ethical guidelines, practice standards, and policy statements highlighting the necessity of protecting confidentiality for adolescents. More than 20 organizations of medical and health care professionals have issued such documents, many of which specifically address family planning services.[28] In particular, the organizations of medical and health professionals most often directly involved in the care of adolescents, such as the American Academy of

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[22] Ford C, English A, Sigman G. Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine. J Adoles Health 2004;35(2):160–167; National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. San Francisco: Family Violence Prevention Fund, 2004. http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf.

[23] 42 C.F.R. § 59.11.

[24] Frost JJ, Gold RB, Bucek A. Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs. Women's Health Issues 2012;22: e519-e525.

[25] 42 C.F.R. § 59.11.

[26] Burke PJ et al. Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine. J Adolesc Health 2014;: 491-496, https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf; Salganicoff A, Ranji U, Beamesderfer A, Kuran N. Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey. Menlo Park, CA: Henry J. Kaiser Family Foundation, May 2014: 28, 38-39, https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf.

[27] Reddy DM, Fleming R, Swain C. Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services. JAMA 2002;288(6):710–714; Jones RK, et al. Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception. JAMA 2005;293(3):340–348; Fuentes L, Ingerick M, Jones R, Lindberg L. Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services. J Adolesc Health 2018;62(1):36-43; Leichliter JS, Copen C, Dittus PJ. Confidentiality Issues and Use of Sexually Transmiiteed Disease Sservices Among Sexually Experienced Persons Aged 15-25 Years – United States, 2013-2015. MMWR Morb Mortal Wkly Rep 2017;66:237-241. DOI: http://dx.doi.org/10.15585/mmwr.mm6608a1.

[28] Policy Compendium on Confidential Health Services for Adolescents, 2d Ed. Chapel Hill, NC: Center for Adolescent Health & the Law, 2005. http://www.cahl.org/PDFs/PolicyCompendium/PolicyCompendium.pdf.

Pediatrics and the Society for Adolescent Health and Medicine, have repeatedly stressed the importance of confidentiality.[29]

The Proposed Rule undermines patient confidentiality and access to care in two primary ways: by exerting increased and inappropriate pressure on adolescent patients and their Title X providers to involve family members including parents or guardians in virtually all cases; and by inserting the HHS Secretary improperly into the enforcement of state reporting laws, impacting all Title X patients.

Congress already requires that Title X providers encourage family participation "where practicable."[30] Title X providers, guided by their expertise, training, and experience, as well as extensive practice standards and recommendations, already assist adolescents to involve their families in decisions about family planning services and other key health care matters when realistic and appropriate. For example, the AAP highly encourages the involvement of families in the care of adolescents and young adults as much as possible but recognizes that the confidential provision of sexual and reproductive health care services is important and makes adolescents more likely to access health care, communicate about sensitive topics openly with the provider, and return for follow-up care.[31]

As a consequence, most adolescents already involve their families in decisions about family planning or seek family planning services with their parents' or guardians' knowledge.[32] However, when taking a health history, careful clinicians sometimes learn of circumstances (short of abuse) in a minor's family that make it not "practicable," or unrealistic or even harmful, to encourage the minor to involve their parents or guardian. In these situations, they should not be required to take "specific actions" to encourage the minor to do so (and then document those specific actions) as the Proposed Rule requires.[33] Doing so is not only contrary to medical ethics, but it also undermines the relationship between the minor and the health care professional and is likely to drive some minors away from returning for critical health care services, including contraception and testing and treatment for sexually transmitted infections.[34]

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[29] E.g., Contraception for Adolescents. Committee on Adolescence. Pediatrics. Sep 2014, peds.2014-2299; DOI: 10.1542/peds.2014-2299; Ford C, English A, Sigman G. Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine. J Adoles Health 2004;35(2):160–167. Burstein GR, Blythe MJ, Santelli JS, English A. Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process," J Adolesc Health 2016; 58:374-377.

[30] 42 U.S.C. 300.

[31] Marcell AV, Burstein GR, AAP COMMITTEE ON ADOLESCENCE. Sexual and Reproductive Health Care Services in the Pediatric Setting. *Pediatrics*. 2017;140(5):e20172858; Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE Jr. Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care. A Randomized Controlled Trial. JAMA 1997;278(12):1029–1034.pmid:9307357.

[32] Diane M. Reddy, Raymond Fleming, and Carolyne Swain, "Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services," *JAMA* 288, no. 6 (2002): 710–714; Rachel K. Jones, et al., "Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception," *JAMA* 293, no. 3 (2005): 340–348; Liza Fuentes, Meghan Ingerick, Rachel Jones, and Laura Lindberg, "Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services," *Journal of Adolescent Health* 62, no. 1 (2018):36-43.

[33] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25530.

[34] Reddy DM, Fleming R, Swain C. Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services. JAMA 2002;288(6):710–714; Jones RK, et al. Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception. JAMA 2005;293(3):340–348; Fuentes L, Ingerick M, Jones R, Lindberg L. Adolescents' and Young

Not only does the Proposed Rule impose excessive requirements related to encouraging family involvement, it would empower HHS to engage in compliance efforts with respect to state reporting laws that exceed the purview of HHS. This could lead to incorrect reporting and confusion by medical providers in ways that would lead adolescent patients to avoid seeking care.

Title X providers are required by state law to comply with a variety of reporting requirements, including child abuse reporting laws. Professionals providing services in Title X-funded sites are aware of these reporting obligations, receive regular training on them, and make reports to comply with these requirements. Health care professionals take seriously not only their reporting obligations but also their obligations to their patients to protect them from real risks of exploitation and abuse.[35]

The reporting laws are complex, nuanced, and varied and are enforced by state authorities. Some state laws include both specific requirements that clearly trigger an obligation to make a report and others that allow for the exercise of discretion by health care professionals. For example, determinations of "reasonable suspicion" and "likelihood of harm" may be within the purview of health care providers who are mandated reporters.[36] However, the Proposed Rule gives HHS substantial oversight over compliance by Title X providers with these complicated state reporting requirements, and the authority to impose harsh penalties if HHS (not the state) believes a Title X project is out of compliance.[37]

Given the complexity, nuances, and variations, HHS has not and should not oversee compliance with state (or local) reporting laws, as doing so is both outside HHS' authority and expertise and is likely to harm patients. Nevertheless, the Proposed Rule would prohibit projects from receiving Title X funds unless the project provides "appropriate documentation or other assurance satisfactory to the Secretary" of HHS that it has met the compliance requirements[38] and states that continuation of funding "is contingent upon demonstrating to the satisfaction of the Secretary" that the requirements have been met.[39]

Providers should use their best clinical judgment about the right time to ask adolescents about victimization as it can take time to develop a relationship of trust between a provider and a patient who has been victimized. The Proposed Rule requires that, irrespective of state requirements, Title X entities commit to "conduct a preliminary screening" of all teens who present with an STD or pregnancy in order to rule out victimization of a minor. Requiring a provider to affirmatively rule out victimization, even when there is no indication of abuse, has the real potential to leave a patient feeling stigmatized and judged simply for seeking family planning care. Patients who feel judged by their health care provider are less likely to return for care.

Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services. J Adolesc Health 2018;62(1):36-43.

[35] Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse—Position Paper of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, Society for Adolescent Health and Medicine. Journal of Adolescent Health 2004;35(5):420-423.

[36] *See e.g.* Rebecca Gudeman and Erica Monasterio, Mandated Child Abuse Reporting Law: Developing and Implementing Policies and Training. National Center for Youth Law and Family Planning National Training Center for Service Delivery, 2014, http://www.cardeaservices.org/documents/resources/Mandated-Child-Abuse-Reporting-Law-GUIDE-20140619.pdf.

[37] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25532-25533.

[38] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25532-25533.

[39] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25533.

The increased oversight by HHS, together with the addition of new requirements to collect and document specific information in Title X records, is likely to cause Title X providers to conduct screenings and make reports to authorities against their best clinical judgment, which will harm patients and undermine the provider-patient relationship, driving some patients away from critical health services. It also turns health care providers into interrogators and directs Title X funds toward unduly excessive policing and record-keeping, rather than toward providing evidence-based care.

Collectively, the onerous and invasive requirements undermine trust in the provider-patient relationship and could cause patients to avoid seeking care in Title X settings, if they seek care at all. AAP and SAHM are deeply committed to protecting adolescent and young adult patients who may be victims of abuse or other criminal activity and our members who are health care professionals take their roles as mandatory reporters very seriously. None of these goals can be achieved if the trust our patients have in their providers is so eroded by unnecessary and prescriptive regulations that patients are no longer comfortable seeking care at all. It is unclear why HHS is trying to inject itself even more into the realm of state law enforcement and to create these additional, unnecessary hurdles for patients and for Title X entities that are already required to ensure their compliance with reporting requirements. There is no evidence that they are not doing so.

IV. The Proposed Rule undermines access to the most effective evidence-based family planning methods.

Title X has contributed to the dramatic decline in the unintended pregnancy rate in the United States, now at a 30-year low.[40] Improved access to contraception and information for adolescents, including those served by Title X projects, has contributed to a record low teen pregnancy rate.[41] The services provided by Title X projects help prevent nearly one million unintended pregnancies each year.[42] The Proposed Rule threatens to reverse this historic progress.

The Proposed Rule removes the requirement that methods of family planning be "medically approved," instead placing increased emphasis on the provision of natural family planning and "other fertility-awareness based methods."[43] Indeed, the Proposed Rule encourages the inclusion of more providers within a Title X project that only offer a single method or very limited methods, and shows a clear preference for organizations providing these less effective methods. Thus, the Proposed Rule would permit entities to participate in Title X that refuse to provide the broad range of contraceptive methods that have been a core part of Title X-funded services since the program's inception, putting at risk access to the most effective forms of contraception, such as long-acting reversible contraception (LARC).[44] Limiting access to the most effective methods of family planning is especially harmful to adolescents and young adults, an age group in which LARC and other hormonal contraceptive methods have been

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[40] Finer LB, Zolna MR, Declines in Unintended Pregnancy in the United States, 2008–2011. N Engl J Med 2016; 374:843–852.
[41] Martin JA, Hamilton BE, Osterman MJ, Driscoll AK, Drake P. (2018). Births: Final data for 2016. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf – PDF.
[42] Guttmacher Institute. Fact Sheet: Publicly Funded Family Planning Services in the United States. September 2016. *Available at* https://www.guttmacher.org/sites/default/files/factsheet/fb_contraceptive_serv_0.pdf
[43] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25530.
[44] Secura G et al., The Contraceptive CHOICE Project: Reducing Barriers to Long-Acting Reversible Contraception. Am J Obstet Gynecol. 2010 Aug; 203(2): 115.e1–115.e7. http://doi.org/10.1016/j.ajog.2010.04.017

associated with decreased rates of teen and unintended pregnancy.[45] Additionally, this provision of the Proposed Rule directly contravenes AAP and SAHM policy regarding contraception for adolescents. It is AAP and SAHM policy that adolescents have access to the full range of contraceptive services that are safe and appropriate for them, including the most highly effective LARC.[46]

The preamble of the Proposed Rule appears to justify this new emphasis by stating that "it has become increasingly difficult and expensive for a Title X project to offer all acceptable and effective forms of family planning."[47] However, the Proposed Rule does not provide evidence to support this statement. In fact, a recent study by the Kaiser Family Foundation and George Washington University found that Title X-funded health centers are far more likely than non-Title X-funded health centers to provide effective family planning methods onsite and to offer services associated with high quality care.[48]

All people seeking care from Title X projects, including adolescents and young adults, should have access to the contraceptive method that works best for their individual circumstances. We are concerned that the Proposed Rule lowers the threshold on the contraceptive services available at Title X-funded sites, restricting access to safe and effective contraception, and negatively impacting the quality of care provided to patients. If implemented, the Proposed Rule threatens to reverse decades of progress, including our nation's historic achievements in reducing unplanned and teen pregnancy rates.

V. The Proposed Rule excludes qualified providers, putting at risk access to quality family planning services for millions of patients.

The Proposed Rule seeks to exclude certain qualified providers from the Title X program by imposing a broad range of financially and administratively burdensome regulatory requirements that are completely unrelated to the goals of the Title X program, putting at risk access to critical primary and preventive care services for more than 40 percent, or nearly two million Title X patients.[49] The government has no role in picking and choosing among qualified providers.

When qualified providers are excluded from publicly funded programs serving low-income patients, other providers are unable to adequately fill the gap, creating barriers to care for patients. When certain qualified providers were excluded from a state program serving low-income patients, the number of

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[45] Secura GM, Madden T, McNicholas C, Mullersman J, Buckel CM, Zhao Q, Peipert JF Provision of No-cost, Long-acting Contraception and Teenage Pregnancy. N Engl J Med 2014 Oct 2;371(14):1316-23. doi: 10.1056/NEJMoa1400506. Ricketts S, Klingler G, Schwalberg R. Game Change in Colorado: Widespread Use of Long-acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-income Women. Persp Sex Reprod Health 2014 Sep;46(3):125-32. doi: 10.1363/46e1714. Epub 2014 Jun 24.

[46] AAP Committee on Adolescence. Contraception for Adolescents. Pediatrics. 2014. doi:10.1542/peds.2014-2299; Burke PJ et al. Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine. J Adolesc Health 2014;: 491-496, https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf.

[47] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25516.

[48] Wood SF et al., George Washington University. Community Health Centers and Family Planning in an Era of Policy Uncertainty. Kaiser Family Foundation. March 2018. http://files.kff.org/attachment/Report-Community-Health-Centers-and-Family-Planning-in-an-Era-of-Policy-Uncertainty

[49] Frost J, Frohwirth L, Blades N, Zolna M, Douglas-Hall, A, Bearak, J. Publicly Funded Contraceptive Services at U.S. Clinics, 2015. Guttmacher Institute. April 2017. https://www.guttmacher.org/sites/default/files/report_pdf/publicly_funded_contraceptive_services_2015_3.pdf

women using the most effective methods of birth control decreased by 35 percent and the number of births covered by Medicaid increased by 27 percent.[50]

When qualified providers in rural and medically underserved communities are forced to close, public health suffers. In addition to losing access to family planning services, communities also lose access to STI testing and treatment. In 2015, closure of a qualified provider in a rural midwestern town coincided with an alarming HIV outbreak, with reduced access to HIV testing that could have minimized or even prevented the outbreak.[51]

The Proposed Rule would exacerbate racial and socioeconomic disparities in access to care by leaving Title X patients, who are disproportionately black and Latinx, without alternate sources of care. It would also limit access to Title X sites for young low-income patients who have few other options. Restricting access to qualified providers will increase rates of unplanned pregnancy, pregnancy complications, and undiagnosed medical conditions, leaving patients worse off than they are today.

VI. The Proposed Rule redefines "low-income family" to fill a contraceptive coverage gap created by the administration's own actions.

The Proposed Rule would redefine "low-income family" to include women whose employer-based health insurance coverage does not cover contraception due to the employer's religious or moral objections.[52] The Affordable Care Act requires that all non-grandfathered health plans cover an HHS-designated list of women's preventive services, which includes contraceptive services. The administration created a significant gap in that coverage in its interim final rules of October 13, 2017, regarding religious[53] and moral[54] objections to contraceptive coverage, which allow virtually any employer to claim an exemption from the contraceptive coverage requirement.

The Proposed Rule's expanded definition would potentially require Title X providers to fill that gap and provide free contraceptive services to women of all incomes. The Title X program is already underfunded, and the Proposed Rule would result in even fewer resources to serve low-income patients, including adolescents and young adults.

VII. The Proposed Rule radically changes the Title X program and jeopardizes public health and the health of adolescents and young adults.

Policy decisions about public health must be firmly rooted in science, and increase access to safe, effective, and timely care. The Proposed Rule would interfere with the patient-provider relationship, exacerbate disparities for low-income and minority women, men, and adolescents, and harm patient

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[50] Stevenson AJ, Flores-Vazquez IM, Allgeyer RL, Schenkkan P, Potter JE. Effect of Removal of Planned Parenthood from the Texas Women's Health Program. N Engl J Med. 2016 Mar 3;374(9):853-60. DOI: 10.1056/NEJMsa1511902.

[51] Peters PJ, Pontones P, Hoover KW, Patel MR, Galang RR, Shields J, et al. Indiana HIV Outbreak Investigation Team. HIV Infection Linked to Injection use of Oxymorphone in Indiana, 2014-2015. N Engl J Med 2016; 375:229-239. DOI: 10.1056/NEJMoa1515195.

[52] Compliance with Statutory Program Integrity Requirements, 83 Fed. Reg. at 25530.

[53] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act. 82 Fed. Reg. at 47792 (October 13, 2017).

[54] Moral Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act. 82 Fed. Reg. at 47838 (October 13, 2017).

health. In particular the Proposed Rule would harm the health of young patients by limiting confidentiality protections and driving them away from care.

We urge HHS to immediately withdraw the Proposed Rule. Thank you for your full consideration of our comments.

Sincerely,

Colleen A. Kraft

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WOMEN'S HEALTH CARE PHYSICIANS

Office of the President
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July 31, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: HHS-OS-2018-0008; Compliance with Statutory Program Integrity Requirements

Dear Secretary Azar:

The American College of Obstetricians and Gynecologists (ACOG) appreciates the opportunity to submit comments in response to the proposed rule, "Compliance with Statutory Program Integrity Requirements" (Proposed Rule), published in the Federal Register on June 1, 2018 by the Department of Health and Human Services (HHS). The Proposed Rule would fundamentally undermine Title X of the Public Health Service Act ("Title X"). It puts at risk the patient-physician relationship and the high-quality evidence-based care that millions of women, men, and adolescents receive each year. The Proposed Rule constitutes an improper restriction on the practice of medicine that, if implemented, would threaten access to reproductive health options and effective family planning methods for the patients who receive care through Title X. It would also place physicians in ethically compromised situations. It contains arbitrary standards and medically inaccurate terminology and, thus, represents a political attempt to interfere with the health care access available to low-income women, and to improperly restrict care that physicians and other medical professionals serving these populations are able to provide.

ACOG is the nation's leading organization of physicians who provide health services unique to women. As the only national medical specialty society of women's health physicians, ACOG has more than 58,000 members representing more than 90 percent of all board-certified obstetrician-gynecologists (ob-gyns) in the United States. ACOG advocates for policies that ensure access to health care for women throughout their lives and believes that a full array of clinical services should be available to women without costly delays or the imposition of cultural, geographic, financial, or legal barriers. Few federal programs are as important to women's health care access as the Title X program. The services presently available through Title X health care providers include Food and Drug Administration (FDA)-approved contraceptive methods and counseling services, well-woman exams, breast and cervical cancer screenings, screening and treatment for sexually transmitted infections (STIs), testing for HIV, pregnancy testing and counseling, and other patient education and/or health referrals. Title X funds are not used for abortions. ACOG affirms the efforts of its members and other medical providers who practice at Title X-funded facilities to provide access to high-quality reproductive health care to all people regardless of their financial circumstances.

Contrary to the preamble of the Proposed Rule, which states that "the new regulations would contribute to more clients being served, gaps in service being closed, and improved client care that better focuses on the family planning mission of the Title X program,"[i] the proposed changes to the Title X program would jeopardize access to family planning and preventive health care for more than four million low-income women, men, and adolescents, and is antithetical to physicians' codes of ethics and commitment to high-quality patient care. The Proposed Rule is laden with medically inaccurate terminology, prioritizing ideology over scientific evidence, exposing the arbitrary nature of the proposed regulation. For these reasons and those explained in full below, we call for the Proposed Rule's immediate and complete withdrawal.

I. The Title X program plays a critical role in our nation's public health safety net.

As the only federal grant program dedicated exclusively to providing low-income patients with essential family planning and preventive health services and information, Title X plays a vital role in ensuring that safe, timely, and evidence-based care is available to every woman regardless of her financial circumstances. Rates of adverse reproductive health outcomes are higher among low-income and minority women, and unintended pregnancy rates are highest among those least able to afford contraception.[ii] According to the HHS Office of Population Affairs website, "Access to quality family planning and reproductive health services is integral to overall good health for both men and women. Few health services are used as universally. In fact, more than 99 percent of women aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method."[iii]

The care made available to women through the Title X program has contributed to the dramatic decline in the unintended pregnancy rate in the United States, now at a 30-year low.[iv] Improved access to contraception and information for adolescents, including those provided by Title X projects, has contributed to a record low teen pregnancy rate.[v] The services provided by Title X projects help prevent nearly one million unintended pregnancies each year.[vi]

In addition to pregnancy prevention, Title X projects meet other reproductive health needs for women, men, and adolescents. In 2016, Title X projects provided nearly five million STI tests, and provided more than 700,000 Pap tests and 900,000 clinical breast exams.[vii] Further, it is estimated that in 2010 alone, services provided by Title X projects helped avert 53,450 chlamydia infections, 8,810 gonorrhea infections, 250 HIV infections, and 6,920 cases of pelvic inflammatory disease.[viii]

The Title X program has improved the lives of women and their families, enabling many women to achieve greater educational, financial, and employment success and stability. These public health strides help American society in many ways, including by saving taxpayer dollars. Because of the high-quality health care that individuals have received through the Title X program, there is an estimated taxpayer savings of $7.09 for every dollar invested in the Title X program.[ix]

The Proposed Rule would undermine the Title X program and detrimentally restrict the ability of patients to access care. If implemented, the Proposed Rule would limit access to vital preventive and often life-saving services for the more than four million patients seeking care annually at Title X-funded facilities. In addition, it would reverse our nation's historic achievements in reducing unplanned and teen pregnancy rates, and make evidence-based contraception methods

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inaccessible to women who otherwise cannot afford them, turning back the clock on women's health.

II. The Proposed Rule would interfere with the patient-physician relationship, restrict the information available to patients, and hinder the ability of physicians to practice medicine in accordance with their ethical obligations.

ACOG's Code of Professional Ethics for ob-gyns unequivocally states that "the patient-physician relationship is the central focus of all ethical concerns, and the welfare of the patient must form the basis of all medical judgments."[x] The patient-physician relationship is essential to the provision of safe and quality medical care, and political efforts to regulate elements of patient care and counseling can drive a wedge between a patient and her medical provider.[xi] HHS acknowledges in the preamble of the Proposed Rule that:

> "...[O]pen communication in the doctor-patient relationship would foster better over-all care for patients. While the benefit of open and honest communication between a patient and her doctor is difficult to quantify, one study showed that even "the quality of communication [between the physician and patient] affects outcomes . . . [and] influences how often, and if at all, a patient would return to that same physician." Facilitating open communication between providers and their patients helps to eliminate barriers to care, particularly for minorities."[xii]

However, if implemented, the Proposed Rule would put the patient-physician relationship in jeopardy by placing restrictions on the ability of physicians to make available important medical information, permitting physicians to withhold information from pregnant women about the full range of their options, and erecting greater barriers to care, especially for minority populations.

1. *The Proposed Rule includes vague restrictions on counseling and removes the requirement that providers offer nondirective pregnancy options counseling, limiting information available to women.*

ACOG supports a woman's right to decide whether to have children, to determine the number and spacing of her children, and to have the information, education, and access to health services to make those decisions.[xiii] ACOG's Code of Professional Ethics states that physician respect for the right of patients to make their own choices about their health care is fundamental.[xiv] Physicians have an "ethical obligation to provide accurate information that is required for the patient to make a fully informed decision."[xv] Yet, the Proposed Rule removes the requirement that providers receiving Title X funds offer the opportunity for pregnant women to receive nondirective counseling and information about their full range of pregnancy options, including prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. This concerning deletion also removes the exception that counseling of pregnant women exclude those "option(s) about which the pregnant woman indicates she does not wish to receive."[xvi] If implemented, the Proposed Rule would permit providers to withhold information from patients, and would permit, and in some cases require, the provision of counseling, information, and referral for services that the patient has clearly stated she does not wish to receive. In the case where a patient seeks counseling once pregnant, under the Proposed Rule a provider would not be permitted to offer such counseling, and instead would be required to provide the patient with a list of prenatal and/or social services, and would require that the patient "be provided with

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information necessary to protect her health and the health of her unborn child."[xvii] ACOG opposes efforts to restrict the medical information that Title X providers can make available to their patients, especially where, as here, the restriction would prevent Title X providers from sharing complete and accurate medical information necessary to ensure that their patients are able to make fully informed medical decisions and obtain timely care.[xviii] Moreover, it is imperative that HHS, the nation's foremost health policy agency, understand and orient all of its activities on a foundation firmly based on scientifically valid and appropriate terms and evidence. The term "unborn child" used in §59.14(b) of the Proposed Rule is not a medical term and should not be used in regulations governing a federal public health program. The agency's use of terms such as this only further emphasizes the fact that the Proposed Rule is ideologically driven and does not align with evidence-based medicine.

In addition to improperly restricting a physician's ability to provide complete and accurate information to his or her patients, the requirements in the Proposed Rule surrounding what information a physician is permitted to share during nondirective counseling are vague and confusing. Specifically, the Proposed Rule contains a new requirement that grantees are not permitted to "promote, refer for, support, or present" abortion as a method of family planning.[xix] It is unclear to what extent counseling that references abortion would be permissible. For instance, would sharing ACOG's patient education document, Frequently Asked Questions #168 "Pregnancy Choices: Raising the Baby, Adoption, and Abortion" be considered a violation?[xx] Without additional guidance, grantees may interpret this language as a complete prohibition on any conversation with their patients that references abortion. At a minimum, these changes would have a chilling effect on providers, who could fear even mentioning the word abortion while counseling a patient on their options would violate the Title X regulations. Merely stating in the preamble of the Proposed Rule that "a doctor would be permitted to provide nondirective counseling on abortion," while subjecting that counseling to vague and confusing restrictions, is not sufficient to describe the requirements the Proposed Rule is seeking to impose.

2. *The Proposed Rule dictates how physicians treat their patients, denies the ability of physicians to refer for abortion care, and discriminates among providers.*

Safe, legal abortion is a necessary component of women's health care. In the United States, where nearly half of all pregnancies are unintended, almost one third of women will seek an abortion by age 45.[xxi] Despite reductions in the unintended pregnancy and abortion rates in recent years, rates remain higher among low-income and minority populations.[xxii] Many factors influence or necessitate a woman's decision to seek abortion care. They include, but are not limited to, contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, and exposure to teratogenic medications. Additionally, pregnancy complications may be so severe that an abortion is the only measure to preserve a woman's health or save her life.[xxiii] As is acknowledged in the preamble of the Proposed Rule, Title X funds have never been used for abortion. However, the Proposed Rule goes beyond the statute in an effort to further restrict access to abortion care outside of the Title X program.

Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties. Like all patients, women obtaining abortion are entitled to privacy, dignity, respect, and support.[xxiv] The Proposed Rule inappropriately regulates provider interactions with patients, going so far as to

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detail restrictions governing when a provider may offer certain referral information, and dictate how that information may be shared.

ACOG's Code of Professional Ethics states that ob-gyns should "serve as the patient's advocate and exercise all reasonable means to ensure that appropriate care is provided to the patient."[xxv] Yet, under the Proposed Rule, only when a patient who is currently pregnant "clearly states that she has already decided to have an abortion," is a physician permitted to share a list of "licensed, qualified, comprehensive health service providers (some, but not all, of which also provide abortion, in addition to comprehensive prenatal care)."[xxvi] This provision could be read to arbitrarily deny the ability of a physician to provide a referral to a woman who decides after presenting to a Title X facility for care to have an abortion. In addition, the Proposed Rule states that "The list shall not identify the providers who perform abortion as such."[xxvii] This proposed regulation restricts the ability of physicians to provide clear, direct information to patients, and it even goes so far as to actively require physicians to withhold full and accurate information and provide referrals to providers that do not offer the service requested by the patient.

The Proposed Rule further clarifies in the examples provided in proposed §59.14(e) that projects do not have to provide any referrals to abortion providers, even if directly requested by the patient, meaning that these changes would also lead to inconsistency in the information offered to patients at different Title X facilities. These provisions represent an improper intrusion into the patient-physician relationship, the importance of which is underscored in the preamble of the Proposed Rule. HHS has provided no justification for this complex and incredibly prescriptive requirement, nor is it supported by the statute. The result of such a regulation would be to mislead patients and delay their access to abortion care, placing providers in ethically compromised positions.

As written, the Proposed Rule requires that a list of referrals for abortion defined by proposed §59.14(a) be provided by a medical doctor, and the preamble of the Proposed Rule suggests that counseling is also confined to a physician. This restriction will unnecessarily further limit access to information that can be – and often is today – provided by a qualified non-physician provider, and delay care for patients. ACOG recognizes that advanced practice clinicians, such as nurse-midwives, physician assistants, and nurse practitioners, possess the clinical skills necessary to provide first-trimester medical abortion.[xxviii] There is no question that these non-physician providers are qualified to provide counseling and referrals to patients. In addition, roughly half of counties in the United States lack an ob-gyn, and those shortages are exacerbated in rural and underserved communities.[xxix] Ob-gyn workforce shortages are expected to increase – not decrease – in the coming years, with a projected shortage of 18 percent by 2030.[xxx] Through arbitrarily limiting the providers who can provide referrals to physicians, the Proposed Rule erects an unnecessary and unsupported barrier to care.

The requirement that the list of referral providers be restricted only to those physicians who provide comprehensive prenatal care (as opposed to providers who only offer gynecological services) would further limit the care options offered to patients, and is not consistent with evidence-based medicine. The Proposed Rule would exclude physicians and medical providers who specialize in the provision of abortion and contraception. In addition, the Proposed Rule's restrictions on referred providers would exclude older ob-gyns who have retired their obstetric practice but continue to provide gynecologic care, including abortion. According to ACOG's 2015 Survey on Professional Liability, the average age at which surveyed physicians stopped

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practicing obstetrics was 48 years, which is considered the near-midpoint of a physician's career.[xxxi]

In cases where a patient is pregnant and does not "clearly state" her decision to have an abortion, the Proposed Rule requires that the patient be "referred for appropriate prenatal and/or social services (such as prenatal care and delivery, infant care, foster care, or adoption), and shall be given assistance with setting up a referral appointment to optimize the health of the mother and unborn child."[xxxii] In addition to the inappropriate use of nonmedical language, as already addressed, proposed §59.14(b) undermines the patient-physician relationship, and is not reflective of the realities of that relationship, where a patient regularly seeks the counsel of their provider. It is also counter to the ethical obligations that physicians have to provide a pregnant woman who may be ambivalent about her pregnancy full information about all options in a balanced manner, including raising the child herself, placing the child for adoption, and abortion. ACOG has long recognized the physician's "ethical obligation to provide accurate information that is required for the patient to make a fully informed decision."[xxxiii]

The restrictions on counseling and referral information that can be shared by Title X providers may put them at increased risk of medical liability. As one example, the decision in *Wickline v. State of California* found that "it is no defense in a medical liability case to argue that physicians simply have followed a payer's instructions."[xxxiv] Ob-gyns already face greater liability risks than many of their physician colleagues, and many ob-gyns report changing their practice due to liability risks. Of those ob-gyns surveyed by ACOG in 2015, "delay in or failure to diagnose" was cited as one of the top three gynecologic liability allegations.[xxxv] By restricting the provision of clear, direct referrals to patients, based on the politically motivated requirements in proposed §59.14(a), the patient is faced with unnecessary barriers and delayed access to care, placing Title X providers at elevated risk of liability.

Restrictions on counseling and referrals undercut a woman's access to safe, legal abortion and jeopardize quality of care. The Institute of Medicine (now National Academy of Medicine) study titled "Crossing the Quality Chasm: A New Health System for the 21st Century" defines high quality care as health care that is safe, effective, patient-centered, timely, efficient, and equitable.[xxxvi] Any changes to the regulations governing the Title X program should aim to advance the quality of care received, in order to best meet patient needs and improve the safety, reliability, responsiveness, integration and availability of care. ACOG has long recognized that "[l]aws [or regulations] should not interfere with the ability of physicians to determine appropriate treatment options and have open, honest, and confidential communications with their patients. Nor should laws [or regulations] interfere with the patient's right to be counseled by a physician according to the best currently available medical evidence and the physician's professional medical judgment."[xxxvii] The Proposed Rule's restrictions on counseling and referral for abortion are a violation of the patient-physician relationship, undermine the quality of care provided to patients, place physicians in ethically compromising situations, and, accordingly, should not be implemented.

III. The Proposed Rule's onerous new reporting requirements for grantees raise safety concerns and are not required to ensure statutory compliance.

The Title X program, as currently regulated, has considerable oversight and reporting requirements. Yet, the Proposed Rule seeks unprecedented additional oversight of Title X

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grantees' subrecipients, referral agencies and individuals, and other partners. The stated purpose of the newly proposed §59.5(a)(13) is to "ensure transparency in the delivery of services" by requiring that all grant applications and required reports include (1) name, location, expertise, and services provided or to be provided by subrecipients, referral individuals and agencies; (2) detailed description of collaboration with those entities, as well as less formal community partners; and (3) a clear explanation of how a grantee will "ensure adequate oversight and accountability for the quality and effectiveness of outcomes" for patients seen by subrecipients or referrals.[xxxviii] The preamble appears to call into question the "governmental accountability for [Title X] funds" if HHS does not have this information, but does not offer any evidence to support this claim and fails to adequately justify these new requirements, nor account for the added costs to grantees.[xxxix] These requirements are burdensome at best and dangerous at worst; they do not improve patient care and are contradictory to other initiatives currently being undertaken at HHS.

1. *The Proposed Rule is inconsistent with other administrative efforts to reduce regulatory burden.*

President Donald Trump's Executive Order to "lower regulatory burdens on the American people," and the Centers for Medicare and Medicaid Services' (CMS) initiative titled "Patients Over Paperwork" are representative of an Administration-wide effort to reduce unnecessary regulatory burdens in federal programs, in particular those that impact health care providers.[xl] The stated goals of the Patients Over Paperwork initiative are to streamline regulations in order to "reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience."[xli] Despite this trend elsewhere within the Administration and HHS, the Proposed Rule seeks to add to the regulatory burden of the Title X program, by implementing new costly and time-consuming reporting requirements.

2. *The Proposed Rule's requirement that grantees report on all referral agencies and individuals, including services provided, is burdensome and raises safety concerns.*

It is not standard practice for providers to keep a dedicated and exhaustive list of all of the providers they interact with, whether through referral or consultation, nor to keep a comprehensive list of the services provided by those colleagues. The Proposed Rule would require Title X-funded entities to track services among referral networks that they are not funded to provide, and appears to suggest that Title X-funded entities would be held accountable for outcomes of patients who receive services at other facilities. This is outside the scope and purpose of the Title X program, and holds Title X providers to an unreasonable standard that is inconsistent with other federally-funded programs.

The collection and reporting to HHS of the names, locations, expertise, and services provided by referral agencies and individuals, as required by proposed §59.5(a)(13)(i), raises several serious questions and concerns. For instance, what happens if a referral agency or individual is inadvertently left off of an application or report to HHS? Is a patient then unable to be referred to or receive care from that agency or individual? Alternatively, how would HHS manage a request by an agency or individual that wishes to be removed from a reported list? In addition, because the Proposed Rule only permits referral for abortion to providers who also offer comprehensive prenatal care, proposed §59.5(a)(13)(i) would require grantees to provide the names and locations of those providers who may not otherwise advertise their abortion services to the

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public. It is unclear what purpose collecting this information would serve aside from establishing an inventory or registry at HHS of the names and locations of abortion providers. Abortion providers face violence and threats to themselves, their staff, and their families.[xlii] The Proposed Rule provides no assurance of confidentiality for those referral providers listed, nor does it provide a guarantee that the information would not be used for other purposes.

HHS seeks comment on whether HHS should impose additional policies or requirements on referral agencies, specifically "expanding the requirement that referral agencies that do not receive Title X funds but nevertheless provide information, counseling, or services to Title X clients be subject to the same reporting and compliance requirements as do grantees and subrecipients."[xliii] Such an expansion of reporting requirements is well beyond the scope of the Title X program and should not be pursued. Requiring providers that do not receive federal Title X funding to comply with onerous reporting requirements is inappropriate and would serve as a disincentive for those providers to serve as referrals for Title X patients. This would exacerbate barriers to specialty care already faced by low-income patients, particularly those living in rural or other underserved communities.[xliv]

IV. The Proposed Rule undermines access to evidence-based family planning methods.

All people seeking care in Title X programs should have access to the contraceptive method that works best for their individual circumstances. We are concerned that the Proposed Rule lowers the threshold on the contraceptive services available at Title X-funded organizations, limiting access to a woman's contraceptive method of choice, and negatively impacting the quality of care provided to patients. The Proposed Rule also appears to prioritize new Title X projects that do not offer a broad range of the most effective contraceptive methods. Collectively, if implemented, these changes will result in reduced access to the most effective contraception methods, threatening to reverse decades of progress, including our nation's historic achievements in reducing unplanned and teen pregnancy rates.

1. *The Proposed Rule lowers the standards for what family planning services must be offered.*

As stated above, ACOG supports a woman's right to decide whether to have children, and to determine the number and spacing of her children. ACOG believes a woman must have unhindered access to information, education, and health services, including the full range of contraceptive methods, in order to make the best decision for herself and her family.[xlv] Currently, Title X projects must provide a "broad range of acceptable and effective medically approved family planning methods (including natural family planning) and services."[xlvi] Access to "the full range of FDA-approved contraceptive methods" has likewise been deemed an essential feature of quality family planning by the U.S. Office of Population Affairs, which administers Title X, and the Centers for Disease Control and Prevention in their authoritative clinical guidelines for quality care, the Quality Family Planning (QFP) recommendations.[xlvii] Despite this body of evidence, the Proposed Rule removes the requirement that methods of family planning be "medically approved," instead placing increased emphasis on the provision of natural family planning (NFP) and "other fertility-awareness based methods."[xlviii] In contrast, the QFP recommendations emphasize that family planning care should be "medically accurate, balanced, and provided in a nonjudgmental manner."[xlix] This modification to the requirements that must be met by family planning projects, together with the newly proposed definition of "family

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planning" appears to be diluting long-standing Title X program requirements, lowering the standards governing the services that must be offered. These changes threaten the quality of family planning available to Title X patients. In addition, the Proposed Rule inserts "adoption" as a service to be offered by a family planning project.[l] Such an expansion of services is puzzling and appears outside the intended scope of the Title X program.

2. *The Proposed Rule's permissive language may result in fewer Title X-funded sites providing the broad range of contraceptive methods that have been a core part of the program since its inception.*

The current regulations allow, though do not encourage, organizations receiving Title X funds to offer only a single method of family planning "as long as the entire project offers a broad range of family planning services."[li] The Proposed Rule is much more permissive, appearing to encourage the inclusion of more providers within a Title X project that only offer a single contraceptive method or very limited methods, putting at risk access to the most effective – and often most desired and expensive – forms of contraception, such as long-acting reversible contraception (LARC).[lii]

The Proposed Rule appears to justify this new emphasis by stating in the preamble that "it has become increasingly difficult and expensive for a Title X project to offer all acceptable and effective forms of family planning."[liii] However, the Proposed Rule does not provide evidence to support this statement. In fact, a recent study by the Kaiser Family Foundation and George Washington University found that Title X-funded health centers are far more likely than non-Title X-funded health centers to provide a larger range of effective family planning methods onsite and to offer services associated with high quality care.[liv] This study found that health centers that receive Title X funds were nearly twice as likely to offer onsite dispensing of oral contraceptives (78 percent versus 41 percent) and more than 1.5 times more likely to offer LARCs, including the contraceptive implant and intrauterine devices (IUDs).[lv] In fact, the availability of onsite oral contraceptive pills has significantly decreased among clinics that do not receive Title X funding, from 53 percent in 2011 to 41 percent in 2017.[lvi] While the Proposed Rule suggests the proposed changes would improve access to and quality of care provided at Title X-funded sites, evidence indicates that Title X-funded sites are more likely than non-Title X-funded sites to follow recommendations of the U.S. Preventive Services Task Force and QFP recommendations, such as screening sexually active women age 25 or younger for chlamydia that can result in infertility if untreated.[lvii,lviii]

Additionally, while Title X does not currently require each service site to offer the full range of contraceptive methods, Title X service sites are required to consult with existing local and regional projects that serve the same population. The Proposed Rule removes the requirement that new Title X applicants communicate with existing health resources serving the same area. By removing this requirement for open communication and coordination between service sites for a shared population, there is no assurance that the population in a particular area has sufficient access to a broad range of the most effective methods of contraception. The Proposed Rule erroneously argues that "loosening the status quo" will allow sites a broader reach, but there is no evidence to support this assumption.[lix]

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3. *The Proposed Rule appears to give preference to Title X projects that provide only limited contraception options, risking access to comprehensive contraceptive care for large parts of the traditional Title X population.*

By lowering the threshold for participation in the Title X program, we are concerned that HHS will prioritize organizations with little or no experience providing sexual and reproductive health care. While NFP and fertility awareness-based methods of family planning have always been included in the full range of contraceptive options offered to women seeking family planning care, the new emphasis on NFP in the Proposed Rule is a major departure from the previous focus on counseling women on the most effective methods. When fertility awareness is used to prevent pregnancy, in the first year of typical use, as many as one in four women will have an unintended pregnancy.[lx] Underserved women, including those who are low-income, already experience the highest rates of unintended pregnancy and abortion, and the Proposed Rule could further exacerbate those disparities.[lxi]

HHS's apparent preference for organizations utilizing fertility awareness-based methods could leave large populations without access to the most effective methods of family planning. Medically underserved populations, including racial and ethnic minorities, LGBTQ individuals, and adolescents will be most harmed by this reduction in access. ACOG's recommendations for adolescent contraceptive care specifically advise that discussions about contraception begin with the most effective methods first.[lxii] Deviating from this recommendation is of significant concern as there is a knowledge gap among this population. Data on unmarried young adults aged 18-29 years in the U.S. suggests misperceptions are common regarding contraception use, and there is a gap between intent and behavior in preventing unintended pregnancy.[lxiii] Encouraging more single-method or limited method service providers within a Title X project will threaten access to comprehensive information about the full range of contraception methods, and is at odds with evidence-based recommendations.

Moreover, the suggested preference for providers offering only NFP methods over medical providers who offer a larger range of FDA-approved contraceptive methods is out of proportion with the known preferences of many Americans. The Proposed Rule contends many people would prefer "single-method NFP service sites," however, utilization of NFP methods in the U.S. is in fact low, with only approximately 2 percent of sexually active women aged 15-44 choosing NFP in 2014.[lxiv,lxv] By contrast, 67 percent of women who use contraception choose more effective methods of contraception (the pill, patch, implant, injectable, vaginal ring, and condom).[lxvi] Clinical recommendations including both the QFP recommendations and the Health Resources and Services Administration-supported Women's Preventive Services Initiative (WPSI) assert that offering the full range of FDA-approved methods is a core component of quality family planning care.[lxvii] The proposed changes would put at risk women's access to their preferred method of contraception. How does HHS plan to ensure that quality care is safeguarded for all Title X patients, including the QFP and ACOG recommendations that women have access to their preferred method of contraception?[lxviii,lxix]

Of note, the preamble of the Proposed Rule references ACOG and WPSI's inclusion of "fertility awareness-based methods" in its clinical recommendations of contraception as a women's preventive service. However, HHS selectively excludes the substance of WPSI's clinical recommendations for contraception, incorrectly suggesting that ACOG either supports fertility awareness-based methods over other methods, or views fertility awareness-based methods as

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equally effective as FDA-approved methods.[lxx] Indeed, the WPSI recommendations were clear that fertility awareness-based methods are "less effective" than FDA approved methods of contraception but should be provided for women desiring an alternative method. To ensure there is no confusion as to ACOG and WPSI recommendations, read in full, the WPSI clinical recommendation for contraception states:

> "The Women's Preventive Services Initiative recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (eg, management, and evaluation as well as changes to and removal or discontinuation of the contraceptive method). The Women's Preventive Services Initiative recommends that the full range of female-controlled U.S. Food and Drug Administration-approved contraceptive methods, effective family planning practices, and sterilization procedures be available as part of contraceptive care.
>
> The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration include: (1) sterilization surgery for women, (2) surgical sterilization via implant for women, (3) implantable rods, (4) copper intrauterine devices, (5) intrauterine devices with progestin (all durations and doses), (6) the shot or injection, (7) oral contraceptives (combined pill), 8) oral contraceptives (progestin only, and), (9) oral contraceptives (extended or continuous use), (10) the contraceptive patch, (11) vaginal contraceptive rings, (12) diaphragms, (13) contraceptive sponges, (14) cervical caps, (15) female condoms, (16) spermicides, and (17) emergency contraception (levonorgestrel), and (18) emergency contraception (ulipristal acetate), and additional methods as identified by the FDA. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method."[lxxi]

It is ACOG's unequivocal position that all women and adolescents should have unhindered and affordable access to comprehensive contraceptive care and contraceptive methods as an integral component of women's health care. The Proposed Rule threatens that access.

V. The Proposed Rule creates substantial burdens on qualified providers and puts at risk access to quality family planning services for low-income women and adolescents.

The Proposed Rule is designed to make it impossible for specialized reproductive health providers, like Planned Parenthood health centers, to continue to participate in the program, by requiring more than mere programmatic separation between Title X project activities and abortion-related activities, including referrals and counseling. These requirements threaten patient access to comprehensive reproductive health care, ignore the significant role specialized providers play in the Title X program, and further marginalize comprehensive reproductive health-focused providers from mainstream medical care.

Requiring complete financial and physical separation is a clear effort to force out reproductive health-focused providers and prioritize providers that do not specialize in reproductive health care. Planned Parenthood plays an outsized role in the Title X program, and the loss of these

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service sites would disproportionately affect medically underserved patients including women of color, who make up more than half of all Title X patients, and women living in rural areas.[lxxii] The Proposed Rule provides HHS broad discretion to evaluate individual Title X funding recipients' compliance with the new physical and financial separation standard, considering at least four factors: (1) separate accounting records; (2) degree of separation of facilities; (3) the existence of separate personnel, electronic or paper-based health care records and work stations; and (4) the extent to which signs and other forms of identification of the Title X program are present, and signs and material referencing or promoting abortion are absent.[lxxiii] These factors reverse HHS's longstanding interpretation that if a Title X grantee can demonstrate separation of financial records, counseling and service protocols, and administrative procedures, "then it is hard to see what additional statutory protection is afforded by the imposition of a requirement for 'physical' separation."[lxxiv] HHS does not adequately justify this reversal.

The preamble of the Proposed Rule states that the "optics and practical operation of two distinct services within a single collocated space are difficult, if not impossible to overcome." However, this statement is not supported by evidence, as can be seen by the emergence of multi-specialty practices (MSPs). MSPs are defined as practices offering various types of medical specialty care within one organization. There is some evidence to suggest these practices may provide higher quality care at a lower cost, when compared to small group practices, including one analysis published in *Health Affairs* that found that patients of MSP providers received more evidence-based care than patients of non-MSP providers.[lxxv]

HHS requests comment on whether additional regulatory provisions are necessary, yet offers no justification for why even this proposed separation is warranted. The proposed reorganization of Title X provider sites will already have significant repercussions on patient access, and should be revoked. No further regulatory modifications should be pursued.

1. *Eliminating specialized reproductive health-focused providers will result in a significant gap in access that the health care system is not equipped to handle.*

Planned Parenthood sites represent only 13 percent of Title X service sites yet serve 41 percent of all Title X patients.[lxxvi] While Planned Parenthood is not explicitly named in the Proposed Rule, the dramatic changes to Title X compliance requirements would have an immense effect on Planned Parenthood service sites. Evidence demonstrates that other providers, including Federally Qualified Health Centers (FQHCs), would not have the capacity to absorb the nearly 2 million contraceptive patients who would lose access to care.[lxxvii] Not all FQHC sites offer contraceptive care services, and among those who do, the average site serves 320 contraceptive clients in a year. By contrast, the average Planned Parenthood health center serves 2,950 contraceptive clients annually.[lxxviii] Moreover, FQHC sites often score lower on critical indicators of quality contraceptive care than Planned Parenthood health centers. For example, Planned Parenthood sites are more likely to offer the full range of contraceptive methods, and specific services such as same-day insertion of LARC methods and on-site dispensing of oral contraceptives.[lxxix]

There is also strong evidence of adverse changes in contraception provision and serious public health consequences in states that have eliminated Planned Parenthood from their family planning programs. When Texas excluded Planned Parenthood from a state program serving low-income patients, the number of women using the most effective methods of birth control

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decreased by 35 percent, and the number of births covered by Medicaid increased by 27 percent.[lxxx] In addition to losing access to family planning services, communities also lose access to STI testing and treatment. When public health funding cuts in Indiana forced many clinics, including Planned Parenthood health centers, to close, rural areas of the state experienced a dramatic HIV outbreak. Access to STI testing at Planned Parenthood clinics could have minimized or even prevented the outbreak.[lxxxi] Targeting comprehensive reproductive health care providers, like Planned Parenthood, puts a larger range of health care services at risk for medically underserved communities.

We are also concerned by the requirement that grantees provide comprehensive primary care on site. Not only is that not a statutorily permissible use of Title X funds, it will further limit eligible entities, cutting otherwise qualified women's health providers from the program. The existing primary care workforce is poorly distributed, with fewer physicians, advanced practice nurses, and physician assistants located in underserved communities, particularly in rural areas. More than half of Planned Parenthood health centers are located in rural and medically underserved areas, helping to minimize the gap in both preventive and reproductive health services for populations in those communities.[lxxxii] If the Proposed Rule were implemented, the U.S. health system would not be prepared to meet this need; both ob-gyns and primary care physicians face workforce shortages. As stated above, ACOG projects an ob-gyn shortage of 18 percent by 2030, and the Association of American Medical Colleges has projected a shortfall of as many as 49,300 primary care physicians and as many as 72,700 nonprimary care physicians by 2030.[lxxxiii,lxxxiv] Limiting the eligibility of current Title X providers would exacerbate this women's health workforce shortage.

The Proposed Rule does suggest applicants can meet this requirement via a robust referral linkage with primary care providers who are "in close physical proximity," but HHS neglects to define this term.[lxxxv] For Title X clinics located in rural areas facing severe primary care provider shortages, how does HHS suggest they meet these new requirements to provide 'holistic' primary care? How will this requirement be measured in health professional shortage areas where there are few primary care providers?

If implemented, the Proposed Rule would exacerbate racial and socioeconomic disparities in access to care by leaving Title X patients, who are disproportionately black and Latinx, without alternate sources of care. Restricting access to qualified providers will increase rates of unplanned pregnancy, pregnancy complications, and undiagnosed medical conditions, leaving patients worse off than they are today.

VI. The Proposed Rule undermines critical confidentiality protections for minors, erecting additional barriers to care.

Family planning services are particularly important for adolescents. The United States has the highest adolescent pregnancy rate in the industrialized world.[lxxxvi] In addition, adolescents and young adults are more likely to acquire sexually transmitted infections than older individuals.[lxxxvii] Projects funded through Title X are expressly required by law to provide care to adolescent patients. The current Title X regulations fulfill this mandate through requiring that Title X facilities provide services to adolescents on a confidential basis. Existing law requires that Title X grantees certify that they encourage minors to include their family in their decisions to seek family planning services.

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The Proposed Rule threatens access to care for adolescents particularly through its weakening of confidentiality protections for adolescents seeking family planning care. Without these protections, adolescents, especially those without adult support systems, may be more likely to delay or not receive needed, sometimes lifesaving care.[lxxxviii] ACOG and other major medical associations support efforts to reasonably encourage adolescents to involve their parents in their decision to seek reproductive healthcare. However, when taking a health history, clinicians sometimes learn of circumstances (short of abuse) in a minor's family that make it not "practicable," or unrealistic or even harmful, to encourage the minor to involve their parents or guardians.[lxxxix] In these situations, clinicians should not be mandated to take "specific actions" to encourage the minor to do so (and then document those specific actions) as the Proposed Rule requires.[xc] ACOG and other major medical associations recommend that adolescents receive confidential, comprehensive reproductive health care without mandated parental notification or consent.[xci] According to the American Academy of Pediatrics, "...policies supporting adolescent consent and protecting adolescent confidentiality are in the best interests of adolescents. Accordingly, best practice guidelines recommend confidentiality around sexuality and sexually transmitted infections (STIs) and minor consent for contraception."[xcii] Ensuring adolescent confidentiality is not only consistent with medical ethics, but also with the importance of ensuring a strong patient-physician relationship.

The Proposed Rule creates barriers to adolescents receiving confidential care. The Title X program should continue to ensure that adolescents are able to access confidential care, while maintaining compliance with all state and federal laws. Failure to do so will erect additional barriers to adolescents seeking preventive and lifesaving reproductive health care and will also undermine the patient-physician relationship.

VII. The Proposed Rule redefines "low-income family" in a way that is contrary to Title X and puts low-income patients presently relying on Title X services at risk of losing access.

The current Title X regulations require that "no charge will be made for services provided to any person from a low-income family" except to the extent that payment can be made by a third-party payer, such as commercial insurance or Medicaid.[xciii] The preamble of the Proposed Rule highlights the increased need for publicly funded family planning services, "as the number of Americans at or below the poverty level has increased," yet at the same time redefines "low-income family" to include women whose employer-based health insurance coverage does not cover contraception due to the employer's religious or moral objections.[xciv,xcv] This expanded definition would potentially require Title X providers to provide free contraceptive services to any woman whose employer objects to insurance coverage of contraception, regardless of her income. HHS has recently expanded the availability of exceptions to the contraceptive coverage requirements of the Affordable Care Act to a broad range of employers. By proposing to expand the definition of "low-income family," the Proposed Rule would greatly increase the number of women who qualify for Title X-funded services, without providing any additional funding or support to ensure the program can sustain this patient increase. The Title X program was not designed to absorb the unmet needs of all individuals above 250 percent of the federal poverty level. Additionally, Title X is designed to subsidize a program of care, not pay the full cost of any service or activity. Title X regulations encourage Title X projects to work with third-party payers to reduce the cost of the program. The Title X program is already underfunded, and

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without additional funding from Congress, the Proposed Rule would result in even fewer resources to serve low-income patients, in direct contrast to the Proposed Rule's stated intent. The Title X network does not have the capacity to serve a flurry of new middle-income patients who have insurance coverage through their employer, nor the resources to serve those patients at low- or no-cost.

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Policy decisions about public health must be firmly rooted in science, and increase access to safe, effective and timely care. Policies and regulations that improperly restrict the practice of medicine, place political preferences over medical necessities, and restrict the ability of millions of women, men, and adolescents to access high quality care should not be implemented. The Proposed Rule would interfere with the patient-physician relationship, exacerbate disparities for low-income and minority women, men, and adolescents, and harm patient health. We urge HHS to immediately withdraw the Proposed Rule. Thank you for your full consideration of our comments.

Sincerely,

Lisa M. Hollier, MD, MPH, FACOG
President

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AMA
AMERICAN MEDICAL ASSOCIATION

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July 31, 2018

The Honorable Alex M. Azar, II
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Compliance with Statutory Program Integrity Requirements (RIN 0937-ZA00), 83 Fed. Reg. 25502 (June 1, 2018)

Dear Secretary Azar:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments to the Department of Health & Human Services (HHS) in response to the Notice of Proposed Rulemaking (Proposed Rule or NPRM) on "Compliance with Statutory Program Integrity Requirements" issued by the Office of Population Affairs (OPA). In its NPRM, HHS proposes to significantly revise the regulations governing the federal Title X family planning program (Title X). The Proposed Rule would withhold federal funds to qualified family planning providers such as Planned Parenthood that also offer abortion services; prohibit in most cases referrals for abortion and restrict counseling about abortion services; eliminate current requirements that Title X sites offer a broad range of medically approved family planning methods and nondirective pregnancy options counseling; and direct new funds to faith-based and other organizations that promote fertility awareness and abstinence as methods of family planning rather than the full range of evidence-based family planning methods.

For the reasons discussed in more detail below, the AMA strongly opposes this Proposed Rule. We are very concerned that the proposed changes, if implemented, would undermine patients' access to high-quality medical care and information, dangerously interfere with the patient-physician relationship and conflict with physicians' ethical obligations, exclude qualified providers, and jeopardize public health. Given our concerns, we urge HHS to withdraw this NPRM.

The Proposed Rule Would Interfere With the Patient-Physician/Provider Relationship

The AMA strongly opposes any government interference in the exam room, especially legislation or regulations that attempt to dictate the content of physicians' conversations with their patients. Protecting the sanctity of the patient-physician relationship, including defending the freedom of communication between patients and their physicians, is a core priority for the AMA. The ability of physicians to have open, frank and confidential communications with their patients has always been a fundamental tenet of high quality medical care.

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. This relationship is built upon trust. A physician must always have the ability to freely communicate with his or her patient, providing information to patients about their health and safety, without fear of intrusion by government and/or other third parties. Regulations that restrict the ability of physicians to explain all options to their patients and refer them, whatever their health care needs, compromise this relationship and force physicians and other health care providers to withhold information that their patients need to make decisions about their care.

The Proposed Rule would violate these core principles by restricting the counseling and referrals that can be provided to patients and by directing clinicians to withhold information critical to patient decision-making. Under section 59.5(a)(5) of the current regulations, Title X projects are required to provide pregnant patients information and counseling regarding the full range of reproductive health options: prenatal care and delivery; infant care, foster care or adoption; and pregnancy termination. If a patient requests such information and counseling, projects must provide neutral, factual information and nondirective counseling on each of the options, as well as referral upon request, except with respect to any option(s) about which the patient indicates she does not want information and counseling.

Specifically, the NPRM eliminates the current requirement that Title X projects provide neutral, factual, nondirective options counseling regarding all of a pregnant patient's options—including abortion—upon request. It appears to be up to each site and organization that participates to decide whether to mention abortion as an option, and it is not exactly clear the extent to which counseling for abortion would be allowed. Although HHS states in the Preamble to the Proposed Rule that a physician—and only a physician—could continue to offer nondirective counseling on abortion as an option, the actual text of the NPRM is silent on this issue.

The Title X statute states that no federal funds appropriated under the program shall be used in programs where abortion is a method of family planning. This provision has generally been interpreted throughout the program's history as meaning that Title X funds cannot be used to pay for or support abortion, which is reflected in the current regulations. However, the NPRM adds vague and confusing language that Title X projects shall not promote, encourage, support, or present abortion as a method of family planning. These terms are not defined in the regulatory text. At the very least, this language could have a chilling effect on physicians and other providers when counseling patients on their options. Moreover, the Proposed Rule requires that Title X projects must refer pregnant patients "for appropriate prenatal and/or social services (such as prenatal care and delivery, infant care, foster care, or adoption)" regardless of a patient's wishes, interest in such a referral, or health status (Section 59.14, NPRM). Title X projects would also be required to assist patients with setting up a referral appointment "to optimize the health of the mother and unborn child." Furthermore, the NPRM would prohibit a Title X project from using prenatal, social service, emergency medical or other referrals as an indirect means of encouraging or promoting abortion as a method of family planning.

In addition to eliminating the requirement for nondirective pregnancy options counseling, the NPRM seeks to ban Title X projects from providing abortion referrals. The Proposed Rule would allow a limited exception if a pregnant patient has already decided to have an abortion and explicitly requests a referral. In this situation, a physician—and no other clinical staff—would be permitted, but not required, to

provide the patient with a list of licensed, qualified, and comprehensive health care providers, some of which may or may not provide abortion services, in addition to prenatal care. However, the list cannot identify the providers that perform abortions and the physician may not indicate which providers on the list offer abortion services. If a pregnant patient does not explicitly state that she has decided to have an abortion, but requests a referral for one, the patient can only be given list of providers which do not provide abortion but do provide prenatal care.

The proposed changes on counseling and referral described above would not only undermine the patient-physician relationship, but also could force physicians to violate their ethical obligations. The inability to counsel patients about all of their options in the event of a pregnancy and to provide any and all appropriate referrals, including for abortion services, are contrary to the AMA's *Code of Medical Ethics*, which provides that patients have the right

> "to receive information from their physicians and to have the opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives…patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment." (Opinion E-1.1.3)

Physicians' inability to comply with their ethical obligations could not only harm the patient-physician relationship, but also could result in harm to their pregnant patients at Title X projects, especially if such patients are delayed in finding abortion providers. Moreover, any restriction on the right of patients and physicians to communicate freely would require assertion of a compelling government interest. While HHS has suggested some general rationales for its proposed amendments, it has not indicated such a compelling interest for the proposed restrictions. In fact, the AMA believes there is no such compelling interest.

The Proposed Rule Would Undermine Access to Evidence-Based Family Planning Methods

The current Title X regulations require funded projects to provide medical services related to family planning and to offer a broad range of acceptable and effective medically approved family planning methods. The NPRM eliminates the requirement that projects offer the full range of family planning methods, and further eliminates "medically approved" from the current regulatory requirement. The Proposed Rule would no longer require that sites follow the Quality Family Planning guidelines of the Centers for Disease Control and Prevention and the OPA. Instead, HHS emphasizes non-medical services, such as abstinence, natural family planning, and adoption as a way to manage infertility. HHS' emphasis on non-medical services is contradicted by data showing that fertility awareness methods are among the least effective methods of family planning, and the Food and Drug Administration has warned that these are not reliable forms of contraception.

Moreover, although the current regulations allow Title X-funded organizations to offer only a single method of family planning, the NPRM is more permissive and seems to encourage more single-method or limited number of methods within a project. These changes could result, for example, in a Title X project that provides only natural family planning and other fertility awareness-based methods, along with abstinence only education for adolescents. These revised provisions change the historic emphasis under both the Title X statute and current regulations that projects must provide a broad range of acceptable and effective medically approved family planning methods.

All individuals seeking care in Title X programs should have access to the contraceptive method that works best for their circumstances. Evidence shows that women who have access to and are able to use the contraceptive method of their choice are more likely to use contraception consistently and effectively, thereby reducing their risk of unintended pregnancy. Contrary to HHS' assertion that its proposed changes will improve access to and the quality of care at Title X projects, the AMA believes that the proposed revisions discussed above will undermine the quality and standard of care upon which millions of women depend for their reproductive health care. Moreover, the Proposed Rule threatens to reverse decades of progress in reducing unintended and teen pregnancy; the United States currently has a 30-year low in unplanned pregnancy and an all-time low in teen pregnancy. Access to affordable contraception, including through programs funded by Title X, has helped make these results possible.

The Proposed Rule Would Inappropriately Exclude Qualified Providers

The Proposed Rule would essentially disqualify any provider that offers abortion services or is affiliated with an abortion provider from receiving Title X funds. It appears designed to make it extremely difficult, if not impossible, for specialized reproductive health providers, such as Planned Parenthood, to continue to participate in Title X. The statute governing Title X requires that program funds can only go to entities where abortion is not a method of family planning. Under current regulations, Title X projects are banned from using Title X funds to pay for abortions and must keep any abortion-related financially separate from their Title X activities. The Proposed Rule, however, would require that Title X activities have full physical and financial separation from abortion-related activities. In addition to separate accounting and electronic and paper health records, providers would need to have separate treatment, consultation, examination and waiting rooms, office entrances and exits, workstations, signs, phone numbers, email addresses, educational services, websites, and staff. HHS fails to justify why physical separation is needed.

Another proposed change would require Title X projects to offer comprehensive primary health services onsite or have a robust referral linkage with primary health providers who are in close physical proximity. This is inappropriate since providing comprehensive primary care services is not a permissible use of Title X funds and the best referrals for Title X funds are not necessarily defined solely by physical proximity. Moreover, some stand-alone family planning clinics, especially in rural areas, may not be near primary health providers, and may not qualify for funding under this requirement.

These provisions, taken as a whole, would make it impossible for clinics like Planned Parenthood and any other provider that also offers abortion services to comply with the new requirements of the program. Furthermore, restrictions on infrastructure support and affiliations would make it impossible for them to continue to participate in Title X. It is unlikely that other providers in many areas of the country, especially in rural and medically underserved communities, would be able to adequately fill the gap left by qualified providers being forced to close.

The implications of these proposed changes are significant, putting at risk access to quality family planning and preventive care services for more than 40 percent, or nearly two million, Title X patients. In states that have excluded certain providers from their family planning programs, research shows serious public health consequences. For example, a study published in the *New England Journal of Medicine* found that blocking patients from going to Planned Parenthood in Texas resulted in a 35 percent decline in women in publicly-funded programs using the most effective forms of birth control and that denying women access to the contraceptive care they needed led to a 27 percent increase in births (among women who had previously used injectable contraception through these program).

Additional Provisions Would Negatively Impact Access to Care

Another proposed change in the NPRM would redefine "low-income family" to include women whose employer-based health insurance coverage does not cover contraception due to the employer's religious or moral objections. This expanded definition would potentially require Title X providers to provide free contraceptive services to women of all incomes. The Title X program is already underfunded and overburdened and the Proposed Rule could result in even fewer resources to serve low-income patients.

The NPRM also threatens patient confidentiality protections, particularly for adolescents. Title X has long required that both adults and adolescents receive confidential family planning services. The current regulations require sites to consider if minors qualify for free family planning services based on their income alone. While the Title X statute encourages family involvement in minors' family planning decisions, the Proposed Rule tries to make such involvement mandatory by changing the definition of "low-income family" to require that Title X providers document in the medical records of unemancipated minors the specific actions taken by the provider to encourage the minor to involve his or her family. This requirement would be a condition of allowing such minors to receive confidential services based on their own resources. This requirement could undermine the provider's expertise and judgment about whether encouraging family participation is feasible or desirable based on the minor's circumstances. In addition, new proposed documentation and reporting requirements, such as the age of each minor patient, the age of each minor's sexual partner(s), if required by law, and special screening of any patient under the age of consent who has a sexually transmitted disease or is pregnant, could undermine the relationship between the minor patient and their Title X provider and prevent such minors who have confidentiality concerns from seeking needed medical services. HHS needs to ensure that Title X projects can continue to provide confidential care for adolescents while complying with all state and federal laws.

In conclusion, Title X is the only federal program dedicated specifically to providing low-income patients with essential family planning and preventive health services and information. As such, it plays a vital role in the nation's public health safety net by ensuring that timely, safe, and evidence-based care is available to women, men, and adolescents, regardless of their financial circumstances. In addition to pregnancy prevention, Title X projects provide other important health services, including sexually transmitted infection testing and treatment, Pap tests, and clinical breast exams. The AMA believes that this Proposed Rule, if finalized, would limit access to critically needed care and services for millions of individuals who depend upon the Title X program for their care and would result in harm to patients and the public's health. We urge HHS to withdraw this proposal.

Sincerely,

James L. Madara, MD

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

June 18, 2019

The Honorable Diana DeGette
U.S. House of Representatives
2111 Rayburn House Office Building
Washington, DC 20515

Dear Congresswoman DeGette:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express the AMA's strong support for the Title X program. Title X is the only federal program dedicated specifically to providing low-income patients with essential family planning and preventive health services and information. In addition to pregnancy prevention, Title X provides other important health services, including sexually transmitted infection testing and treatment, Pap tests, and clinical breast exams. As such, Title X plays a vital role in the nation's public health safety net by ensuring that timely, safe, and evidence-based care is available to women, men, and adolescents, regardless of their financial circumstances. Title X has been extraordinarily successful. Under regulations that have been largely unchanged for decades, a large network of family-planning centers has flourished with enormous benefits to patients, their families, and public health.

On March 5, 2019, the AMA filed a lawsuit (along with Planned Parenthood Federation of America, the Oregon Medical Association, and a practicing physician—see the complaint here) in the U.S. District Court for the District of Oregon to block the implementation of the Administration rule that would decimate the Title X program and limit the medical advice physicians can provide to their Title X patients. The lawsuit came in the wake of new regulations (Final Rule—"Compliance with Statutory Program Integrity Requirements," 84 Fed. Reg. 7,714,) promulgated on March 4, 2019 by the U.S. Department of Health and Human Services (HHS). This Final Rule will, if allowed to stand, limit women's access to health care services and force physicians to withhold information on all health care options available to their patients. In April, the U.S. District Court judge granted a nationwide preliminary injunction against implementation of the new Final Rule restrictions on the Title X program (see the judge's ruling here).

In its Final Rule, HHS proposes to significantly revise the regulations governing the federal Title X family planning program. The rule would withhold federal funds to qualified family planning providers such as Planned Parenthood, that also offer abortion services. It would also: prohibit in most cases referrals for abortion and restrict counseling about abortion services; eliminate

current requirements that Title X sites offer a broad range of medically approved family planning methods and nondirective pregnancy options counseling; and direct new funds to faith-based and other organizations that promote fertility awareness and abstinence as methods of family planning rather than the full range of evidence-based family planning methods.

For the reasons discussed in more detail below and in our court complaint, **the AMA strongly opposes the Final Rule**. We are very concerned that the proposed changes, if implemented, would undermine patients' access to high-quality medical care and information, dangerously interfere with the patient-physician relationship and conflict with physicians' ethical obligations, exclude qualified providers, and jeopardize public health. In addition to our legal argument that the Final Rule be permanently overturned by the Federal Courts, **the AMA urges Congress to swiftly take legislative action to prevent further attempts by the Administration to jeopardize this critical federal health care program.**

The Final Rule Interferes with the Patient-Physician Relationship

The AMA strongly opposes any government interference in the exam room, especially legislation or regulations that attempt to dictate the content of physicians' conversations with their patients. Protecting the sanctity of the patient-physician relationship, including defending the freedom of communication between patients and their physicians, is a core priority for the AMA. The ability of physicians to have open, frank, and confidential communications with their patients has always been a fundamental tenet of high quality medical care.

Since ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. This relationship is built upon trust. A physician must always have the ability to freely communicate with his or her patient, providing information to patients about their health and safety, without fear of intrusion by government and/or other third parties. Regulations that restrict the ability of physicians to explain all options to their patients and refer them, whatever their health care needs, compromise this relationship and force physicians and other health care providers to withhold information that their patients need to make decisions about their care.

The Final Rule violates these core principles by restricting (or "gagging") physicians in their counseling and referrals that can be provided to patients and by directing physicians and other clinicians to withhold information critical to patient decision-making. However, under the rules currently in force, Title X projects are required to provide pregnant patients information and counseling regarding the full range of reproductive health options—prenatal care and delivery; infant care, foster care or adoption; and pregnancy termination. If a patient requests such information and counseling, projects must provide neutral, factual information and nondirective

counseling on each of the options, as well as referral upon request, except with respect to any option(s) about which the patient indicates she does not want information and counseling.

Specifically, the Final Rule eliminates the current requirement that Title X projects provide neutral, factual, nondirective options counseling regarding all of a pregnant patient's options—including abortion—upon request. It would be up to each site and organization that participates to decide whether to mention abortion as an option, and it is not clear the extent to which counseling for abortion would be allowed. Although HHS stated in the Preamble of the Proposed Rule that a physician—and only a physician—could continue to offer nondirective counseling on abortion as an option, the actual text of the Final Rule is silent on this issue.

The Title X statute states that no federal funds appropriated under the program shall be used in programs where abortion is a method of family planning. This provision has generally been interpreted throughout the program's history as meaning that Title X funds cannot be used to pay for or support abortion, which is reflected in the current regulations in force. However, the Final Rule adds vague and confusing language that Title X projects shall not promote, encourage, support, or present abortion as a method of family planning. These terms are not defined in the regulatory text. At the very least, this language could have a chilling effect on physicians and other providers when counseling patients on their options. Moreover, the Final Rule requires that Title X projects must refer pregnant patients "for appropriate prenatal and/or social services (such as prenatal care and delivery, infant care, foster care, or adoption)" regardless of a patient's wishes, interest in such a referral, or health status. Title X projects would also be required to assist patients with setting up a referral appointment "to optimize the health of the mother and unborn child." Furthermore, the Final Rule prohibits a Title X project from using prenatal, social service, emergency medical or other referrals as an indirect means of encouraging or promoting abortion as a method of family planning.

In addition to eliminating the requirement for nondirective pregnancy options counseling, the Final Rule seeks to ban Title X projects from providing abortion referrals. The rule allows a limited exception if a pregnant patient has already decided to have an abortion and explicitly requests a referral. In this situation, a physician—and no other clinical staff—would be permitted, but not required, to provide the patient with a list of licensed, qualified, and comprehensive health care providers, some of which may or may not provide abortion services, in addition to prenatal care. However, the list cannot identify the providers that perform abortions and the physician may not indicate which providers on the list offer abortion services. If a pregnant patient does not explicitly state that she has decided to have an abortion, but requests a referral for one, the patient can only be given a list of providers which may or may not provide abortion but do provide prenatal care.

The changes on counseling and referral described above would not only undermine the patient-physician relationship, but also could force physicians to violate their ethical obligations. The inability to counsel patients about all of their options in the event of a pregnancy and to provide any and all appropriate referrals, including for abortion services, are contrary to the AMA's Code

of Medical Ethics, which provides that patients have the right "to receive information from their physicians and to have the opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives…patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment." (Opinion E-1.1.3).

Physicians' inability to comply with their ethical obligations could not only harm the patient-physician relationship, but also could result in harm to their pregnant patients at Title X projects, especially if such patients are delayed in finding abortion providers. Moreover, any restriction on the right of patients and physicians to communicate freely would require assertion of a compelling government interest. While HHS has suggested some general rationales for this change, it has not indicated such a compelling interest for the proposed restrictions. In fact, the AMA believes there is no such compelling interest.

The Final Rule Would Undermine Access to Evidence-Based Family Planning Methods

The current Title X regulations require funded projects to provide medical services related to family planning and to offer a broad range of acceptable and effective medically approved family planning methods. The Final Rule eliminates the requirement that projects offer the full range of family planning methods, and further eliminates "medically approved" from the current regulatory requirement. The rule no longer requires that sites follow the Quality Family Planning guidelines of the Centers for Disease Control and Prevention and the Office of Population Affairs, which administers the Title X family planning program. Instead, HHS emphasizes non-medical services, such as abstinence, natural family planning, and adoption as a way to manage infertility. HHS' emphasis on non-medical services is contradicted by data showing that fertility awareness methods are among the least effective methods of family planning, and the U.S. Food and Drug Administration has warned that these are not reliable forms of contraception.

Moreover, although the current regulations allow Title X-funded organizations to offer only a single method of family planning, the Final Rule is more permissive and would likely encourage more single-method or limited number of methods within a project. These changes could result, for example, in a Title X project that provides only natural family planning and other fertility awareness-based methods, along with abstinence only education for adolescents. These revised provisions change the historic emphasis under both the Title X statute and current regulations that projects must provide a broad range of acceptable and effective medically approved family planning methods.

All individuals seeking care in Title X programs should have access to the contraceptive method that works best for their circumstances. Evidence shows that women who have access to and are able to use the contraceptive method of their choice are more likely to use contraception consistently and effectively, thereby reducing their risk of unintended pregnancy. Contrary to HHS' assertion that its proposed changes will improve access to and the quality of care at Title X projects, the AMA believes that the proposed revisions discussed above will undermine the

quality and standard of care upon which millions of women depend for their reproductive health care. Moreover, the Final Rule threatens to reverse decades of progress in reducing unintended and teen pregnancy—the United States currently has a 30-year low in unplanned pregnancy and an all-time low in teen pregnancy. Access to affordable contraception, including through programs funded by Title X, has helped make these results possible.

The Final Rule Would Inappropriately Exclude Qualified Providers

The Final Rule would essentially disqualify any provider that offers abortion services or is affiliated with an abortion provider from receiving Title X funds. It would make it extremely difficult, if not impossible, for specialized reproductive health providers, such as Planned Parenthood, to continue to participate in Title X. The statute governing Title X requires that program funds can only go to entities where abortion is not a method of family planning. Under regulations still in force, Title X projects are banned from using Title X funds to pay for abortions and must keep any abortion-related activities financially separate from their Title X activities. The Final Rule, however, would require that Title X activities have full physical and financial separation from abortion-related activities. In addition to separate accounting and electronic and paper health records, providers would need to have separate treatment, consultation, examination and waiting rooms, office entrances and exits, workstations, signs, phone numbers, email addresses, educational services, websites, and staff. HHS fails to justify why physical separation is needed.

Another change will require Title X projects to offer comprehensive primary health services onsite or have a robust referral linkage with primary health providers who are in close physical proximity. This is inappropriate since providing comprehensive primary care services is not a permissible use of Title X funds and the best referrals for Title X funds are not necessarily defined solely by physical proximity. Moreover, some stand-alone family planning clinics, especially in rural areas, may not be near primary health providers, and may not qualify for funding under this requirement.

These provisions, taken as a whole, will make it impossible for clinics like Planned Parenthood and any other provider that also offers abortion services to comply with the new requirements of the program. Furthermore, restrictions on infrastructure support and affiliations would make it impossible for them to continue to participate in Title X. It is unlikely that other providers in many areas of the country, especially in rural and medically underserved communities, would be able to adequately fill the gap left by qualified providers being forced to close.

The implications of these changes are significant, putting at risk access to quality family planning and preventive care services for more than 40 percent, or nearly of two million, Title X patients. In states that have excluded certain providers from their family planning programs, research shows serious public health consequences. For example, a study published in the *New England Journal of Medicine* found that blocking patients from going to Planned Parenthood in Texas resulted in a substantial decline in women in publicly-funded programs using the most

effective forms of birth control and that denying women access to the contraceptive care they needed led to a 27 percent increase in births (among women who had previously used injectable contraception through these program).

Additional Provisions Would Negatively Impact Access to Care

The Final Rule redefines "low-income family" to include women whose employer-based health insurance coverage does not cover contraception due to the employer's religious or moral objections. This expanded definition will potentially require Title X providers to provide free contraceptive services to women of all incomes. The Title X program is already underfunded and overburdened, and this requirement could result in even fewer resources to serve low-income patients.

The Final Rule also threatens patient confidentiality protections, particularly for adolescents. Title X has long required that both adults and adolescents receive confidential family planning services. The regulations currently in force require sites to consider if minors qualify for free family planning services based on their income alone. While the Title X statute encourages family involvement in minors' family planning decisions, the Final Rule tries to make such involvement mandatory by changing the definition of "low-income family" to require that Title X providers document in the medical records of unemancipated minors the specific actions taken by the provider to encourage the minor to involve his or her family. This requirement is a condition of allowing such minors to receive confidential services based on their own resources, and could undermine the provider's expertise and judgment about whether encouraging family participation is feasible or desirable based on the minor's circumstances. In addition, new documentation and reporting requirements, such as the age of each minor patient, the age of each minor's sexual partner(s), if required by law, and special screening of any patient under the age of consent who has a sexually transmitted disease or is pregnant, could undermine the relationship between the minor patient and their Title X provider and prevent such minors who have confidentiality concerns from seeking needed medical services.

In conclusion, the AMA believes that the Final Rule, if allowed to stand, would limit access to critically needed care and services for millions of individuals who depend upon the Title X program for their care and would result in harm to patients and the public's health. We therefore urge Congress to swiftly take legislative action to ensure that the Title X regulations currently in force are maintained and that avert future attempts by the Administration to jeopardize this critical federal health care program.

Sincerely,

James L. Madara, MD

July 30, 2018

Alex Azar, Secretary of Health and Human Services
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Valerie Huber, Senior Policy Advisor, Assistant Secretary for Health
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Diane Foley, Deputy Assistant Secretary for Population Affairs
Office of the Assistant Secretary for Health, Office of Population Affairs
Attention: Family Planning
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

RE: HHS–OS–2018–0008, Proposed Rule for Compliance With Statutory Program Integrity Requirements

Dear Secretary Azar, Senior Advisor Huber, and Deputy Assistant Secretary Foley:

On behalf of the American Public Health Association, a diverse community of public health professionals that champions the health of all people and communities, I appreciate the opportunity to comment on the Department of Health and Human Services' proposed rule entitled Compliance with Statutory Program Integrity Requirements.[1] The proposed rule would significantly and detrimentally alter the Title X Family Planning Program, which has provided vital sexual and reproductive health services to people across the country for more than 40 years, and today provides services to 4 million people in the United States.

As an organization committed to improving the health of the nation, we write to express our strong opposition to this proposed rule. Specifically, the proposed rule would interfere with the doctor-patient relationship and deny Title X patients critical information about their health and

[1] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502 (proposed Jun. 1, 2018) (to be codified at 42 C.F.R. pt. 59).

health care options. Secondly, it is clearly designed to make it impossible for reproductive health-focused providers, like Planned Parenthood health centers, to continue to serve people through the program. Third, it would undermine Title X's goals of providing comprehensive reproductive health services to people with low incomes. Additionally, the proposed rule radically underestimates the likely costs it will impose on patients, providers and on society. Finally, the rule would exacerbate existing health disparities. The combined result of these changes would be disastrous for public health in the United States.

I. The Proposed Rule would interfere with the doctor-patient relationship and deny patients information that they need to make the best decisions for themselves and their families.

The proposed rule would ban Title X providers from giving women full information about their health care options. Specifically, the proposed rule would eliminate the existing requirement that patients be provided with referrals upon request for the full range of pregnancy options, including prenatal care and delivery; infant care, foster care, or adoption; and abortion.[2] That requirement would be replaced with a complete ban on health care providers giving abortion referrals.[3] Many experts call this provision a "gag rule," since it would restrict providers from speaking freely with their patients. The gag rule violates core ethical standards and undermines the patient-provider relationship.

This rule conflicts with a fundamental principle that guides health care providers every day: patients' needs are paramount and providers have an ethical obligation to put the needs of patients first. The prohibition on abortion referrals contravenes medical ethics and leaves providers in the position of not providing the best level of medical care or no longer participating in the Title X program, thereby potentially leaving their patients without access to care at all.

In addition to the prohibition on abortion referral, the proposed rule also eliminates longstanding requirements guaranteeing patients in Title X information about all of their health care options. Title X regulations currently direct Title X projects to "[o]ffer pregnant women the opportunity to be provided information and counseling" on all pregnancy options.[4] All such counseling must be neutral, factual, and nondirective.[5] The proposed rule would eliminate the options counseling requirement in its entirety.

This is problematic for at least two reasons. First, the proposed rule contemplates that some providers would not provide this counseling for asserted religious or moral reasons, but it does not contain any requirement that those providers advise patients of their refusal. Therefore, patients will not even know if they are getting complete information. Second, even for providers who want to offer their patients information about all of their health care options, the proposed rule creates confusion. On the one hand, the preamble includes language stating that doctors (and only doctors) could continue to offer nondirective counseling on abortion as a health care option, the operative language of the rule is completely silent on the subject. Particularly, combined with the prohibition on referrals, providers may not understand whether, or who, can provide abortion counseling to patients that request it.

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[2] 42 C.F.R. § 59.5(a)(5).
[3] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. at 25,531.
[9] 42 C.F.R. § 59.5(a)(5).
[10] *Id.*

Limiting support for comprehensive reproductive health services takes us back to failed policies that harm women's health. The gag rule has been associated with an increase in abortions, an increase in maternal deaths and encouraging unsafe abortions. APHA has long recognized access to the full range of reproductive and sexual health care services, including abortion, as a fundamental right[6]. Without access to these services, the health of women and girls is at risk. These services are essential for women's lives, for population health and for advancing income equality, women's rights and women's individual freedom.

II. The Proposed Rule is clearly designed to make it impossible for specialized reproductive health providers to continue to participate in the Title X program, threatening access to critical care services for thousands of people across the United States.

The proposed rule is clearly designed to make it impossible for reproductive health-focused providers, like Planned Parenthood health centers, to continue to serve patients in Title X. First, the proposed rule would require Title X recipients to physically and financially separate Title X project activities from any of their abortion-related activities, including abortion referrals.[7] These provisions completely ignore that specialized providers have for decades played an important -- and irreplaceable role -- in the Title X program.

The rule would grant broad discretion to HHS to evaluate an individual Title X recipient's compliance with the new physical and financial separation standard by instructing HHS to employ a "facts and circumstances" test in order to determine whether a Title X project has achieved "objective integrity and independence" from abortion-related activities.[8] In its analysis, the agency would be required to consider at least four factors:

1. The existence of separate, accurate accounting records;
2. The degree of separation from facilities (e.g., treatment, consultation, examination and waiting rooms, office entrances and exits, shared phone numbers, email addresses, educational services, and websites) in which prohibited activities occur and the extent of such prohibited activities;
3. The existence of separate personnel, electronic or paper-based health care records, and workstations; and
4. The extent to which signs and other forms of identification of the Title X project are present, and signs and material referencing or promoting abortion are absent.[9]

These factors reverse HHS' longstanding interpretation that, "[i]f a Title X grantee can demonstrate [separation] by its financial records, counseling and service protocols, administrative procedures, and other means . . . , then it is hard to see what additional statutory

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[6] American Public Health Association, Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention (Nov 3, 2015) available at https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights

[11] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. at 25,532.

[12] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. at 25,532.

[13] *Id.*

protection is afforded by the imposition of a requirement for 'physical' separation."[10] A notice issued by HHS further made clear that Title X service sites could use common waiting rooms, staff, and filing systems for abortion-related activities and Title X project activities.[11] HHS fails to justify why this reversal is warranted. Moreover, these factors go even further than a 1988 domestic gag rule issued by the Reagan administration. Even so, HHS states that the standard still may not go far enough in separating Title X services from abortion.

These provisions are clearly designed to destabilize the Title X network by pushing out reproductive health-focused providers and bringing in providers that do not focus on reproductive health care. This would undermine the mission of Title X to increase access to family planning and sexual health care services, including the contraceptive methods of a patient's choice, for low-income, uninsured, underinsured and underserved individuals. Moreover, evidence shows that Title X patients may prefer to see a provider that specializes in reproductive health. Specialized clinics can offer better or faster services such as having oral contraceptives available on site or same day IUD insertion.[12] Also, women trust OB/GYN specialists and are generally more likely to talk with them about health concerns both within and outside the scope of sexual and reproductive health care.[13] Thirty-five percent of women report their OB/GYN being their primary health care provider.[14]

Planned Parenthood plays a critical and outsized role in the Title X program. Nationwide, Planned Parenthood health centers serve more than 40 percent of Title X patients. Eliminating Planned Parenthood from the Title X program would leave many people without access to care. In states that have eliminated Planned Parenthood from their family planning programs, the public health results have been disastrous. For instance, a recent study in the New England Journal of Medicine showed that blocking patients from going to Planned Parenthood in Texas had serious public health consequences.[15] The study found a 35 percent decline in women in publicly funded programs using the most effective methods of birth control. Further, denying women access to the contraceptive care that they needed led to a dramatic 27 percent increase in births among women who had previously accessed injectable contraception through those programs. Moreover, public health officials fear a domestic gag rule, "could cripple federal efforts to stop a dramatic increase in sexually transmitted diseases in the U.S."[16]

III. The Proposed Rule would radically change the Title X program, adversely impacting the health of people across the nation.

The proposed rule would threaten Title X program protections that are designed to ensure access to the full range of contraceptive methods. Currently, Title X projects must, by statute and

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[14] Standards of Compliance for Abortion Related Services in Family Planning Services Projects, 65 Fed. Reg. 41,270, 41,276 (Jul. 3, 2000).
[15] Provision of Abortion-Related Services in Family Planning Projects, 65 Fed. Reg. 41,281, 41,282 (Jul. 3, 2000).
[12] Frost, J.J., Gold, R.B., Bucek A., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*,Women's Health Issues, 22(6) (2012), e519-e525.
[13] PerryUndem, "Research Findings: Women + OB/GYN Providers," (Nov. 2013), available at https://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.
[14] *Id*.
[16] Amanda J. Stevenson et al. "Effect of Removal of Planned Parenthood from the Texas Women's Health Program," New England Journal of Medicine, Vol. 374, available at http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article.
[17] Michelle Andrews, Trump's Redirection Of Family Planning Funds Could Undercut STD Fight, NPR (June 12, 2018), available at https://www.npr.org/sections/health-shots/2018/06/12/618902785/trumps-redirection-of-family-planning-funds-could-undercut-std-fight

regulation, offer a broad range of acceptable and effective family planning methods and services.[17] Access to "the full range of FDA-approved contraceptive methods" has also been deemed an essential feature of quality family planning by the U.S. Office of Population Affairs, which administers Title X, and the Centers for Disease Control and Prevention in their authoritative clinical guidelines for quality care.[18] While HHS cannot alter the statutory requirement that Title X projects offer "a broad range of acceptable and effective family planning methods and services,[19] the proposed rule goes out of its way to emphasize that "projects are not required to provide every acceptable and effective family planning method or service," giving Title X projects authority to exclude methods or services of their choosing.[20] Moreover, the proposed rule would remove the requirement that family planning methods available from Title X projects must be "medically approved."[21]

Collectively, these changes appear intended to allow Title X projects to deny patients access to the full complement of effective contraceptive methods. We are very concerned that this lowering of the threshold for participation in Title X will result in organizations with little or no experience providing sexual and reproductive health care participating in the program, which in turn would inevitably lead to reduced access to a broad range of methods for patients. All people seeking care in Title X programs are entitled to access the contraceptive method that works best for their individual circumstances, and that requires access to all methods of contraception. Indeed, this was the very purpose of the Title X program in the first place. At the time, Congress stated that Title X's purpose was "making *comprehensive* voluntary family planning services readily available to all persons desiring such services."[22]

Moreover, in the proposed rule HHS makes a number of unsupported contentions about the benefits of the rule, including that it would improve access to and the quality of care provided at Title X sites.[23] In fact, the United States is currently experiencing a 30-year low in unintended pregnancy and an all-time low in teen pregnancy. These results have been achieved in large part due to access to affordable contraception - in particular the most effective methods of contraception - including through programs like Title X. This rule threatens to turn back the progress that has been made.

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[18] 42 U.S.C. § 300(a); 42 C.F.R. § 59.5(a)(1). While the entire project is held to the "broad range" standard under the current rules, each participating entity is not. So "[i]f an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of family planning services."

[19] Department of Health and Human Services and Centers for Disease Control and Prevention, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, 2, (Apr. 2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

[20] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. 25,502 (proposed Jun. 1, 2018) (to be codified at 42 C.F.R. pt. 59).

[21] Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. at 25,530.

[22] *Id.* at 25,530.

[23] Pub. L. No. 91-572, § 2(1); see S. Rep. No. 91-1004, at 2 (1970) (emphasis added)..

[24] *See, e.g.,* Compliance With Statutory Program Integrity Requirements, 83 Fed. Reg. at 25,505 ("If finalized and implemented as proposed, the new regulations would contribute to more clients being served, gaps in service being closed, and improved client care that better focuses on the family planning mission of the Title X program"); 83 Fed. Reg. at 25,522 (HHS cites as expected benefits of the proposed rule "Enhanced patient service and care" and also states that the rule "is also expected to increase the number of entities interested in participating in Title X as grantees or subrecipient service provides and, thereby, to increase patient access to family planning services focused on optimal health outcomes for every Title X client").

APHA supports the universal human right to voluntary, informed, affordable access to the full range of modern contraceptive methods, including emergency contraception.[24] Full access to contraceptive coverage is a vital component of preventive health services for women. By enabling women to choose when to have children, contraception improves women's health[25] and economic security.[26] The economic impacts of the proposed rule must be fully considered, including the effect on women's economic security and the additional health costs that result from insufficient preventive health care.

IV. The Proposed Rule fails to account for numerous costs that will be imposed on women, providers and society if it is implemented.

HHS fails to take into account most of the costs that will accrue under this rule. HHS acknowledges that the proposed rule has no quantifiable benefits. At the same time HHS significantly underestimates the projected costs by only erroneously confining its discussion of the rule's costs to include only the costs borne by entities that would have to comply with the rule, but not calculating the considerable additional costs, including for Title X patients who are no longer able to receive the health care services that they need, as well as the resultant health care costs to state and local health systems. Moreover, even HHS's calculations of the logistical and structural costs of compliance are insufficient. Remarkably, because of that failure, HHS has determined that its rulemaking is not "economically significant" because it believes the rule's economic effects would fall short of a $100 million threshold. An accurate analysis of the costs would determine that the costs are significantly greater than $100 million. For instance, the proposed rule's extensive new reporting requirements—from subrecipients to patient medical records—would be far more economically and administratively burdensome than HHS suggests. It would require changes in electronic health record systems and additional time in training and management that far exceed the estimated costs as outlined in the proposed rule. Furthermore, the physical separation requirements would impact all Title X providers, and seek to require wholly separate second sites to be opened in order for Title X-funded organizations to continue separate, non-Title X activities.

V. The Proposed Rule would worsen existing health disparities leaving communities that already experience worse health outcomes with less access to care

All of the harmful impacts laid out above will fall most heavily on the people who are most in need of comprehensive, affordable reproductive and sexual health care services. Because of systemic inequities, the people served by the Title X program are more likely to be people of color and to face language barriers and other barriers to care. This rule will deny people who already face health disparities access to the best possible care through experienced providers and to all methods of contraception.

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[24] American Public Health Association. (2015) Universal Access to Contraception. Accessed October 18, 2017 from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/12/17/09/14/universal-access-to-contraception

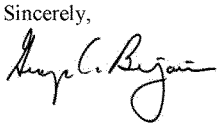
[25] Wendt A, Gibbs CM, et al. (2012) "Impact of increasing inter-pregnancy interval on maternal and infant health. Pediatr Perinat Epidemiol. Accessed October 18, 2017 from https://www.ncbi.nlm.nih.gov/pubmed/22742614

[26] Bailey M, Hershbein B, Miller A. 2012. The Opt-in Revolution? Contraception and the Gender Gap in Wages. National Bureau of Economic Research. Accessed October 18, 2017 from http://www.nber.org/papers/w17922.pdf

For nearly 50 years, the Title X family planning program has been a critical underpinning of the public health safety-net infrastructure that serves millions of low-income people each year. Title X was created to ensure that all people in the United States can access high-quality preventative sexual and reproductive health care. Title X service sites offer free and reduced-cost contraception and health services to low-income and uninsured populations. Of the 4 million patients who visit Title X providers, two-thirds live below the federal poverty level and almost half are uninsured. These health centers provide resources that are necessary for a healthy population, such as cancer screenings, STI testing and treatment, sexual education, and effective contraception, to a population that otherwise has limited access.

This federal program should be preserved and strengthened—not compromised by unnecessary over-regulation and limitations that are contrary to ethical medical practice. For all of these reasons, we strongly urge you to not finalize the proposed rule.

Sincerely,



Georges C. Benjamin, MD
Executive Director

CONCERNED
WOMEN *for* AMERICA
LEGISLATIVE ACTION COMMITTEE

June 19, 2019

The Honorable Frank Pallone
Chairman
House Committee on Energy & Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
House Committee on Energy & Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden,

On behalf of the hundreds of thousands of members of Concerned Women for America Legislative Action Committee (CWALAC), we urge you to uphold the original intent behind Title X funding and honor the American people's longstanding desire to exclude abortion services from this program.

As you know, the Title X Family Planning Program was authorized in 1970 and is intended to assist in "voluntary family planning projects," offering "a broad range of acceptable and effective family planning methods and services," and may not fund "programs where abortion is a method of family planning." The law is clear: there must be a distinction between abortion and Title X family planning funds.

CWALAC wants to make sure that the voices of the millions of women who proudly stand for the sanctity of life and the intrinsic value of every human being, outside or inside the womb, as created in the image of God are not ignored. Women are not a monolithic, single-minded block of people who all support the same things, but a beautiful tapestry of many different expressions that should all be respected and celebrated. Yes, many women support abortion. But many also stand strongly against it.

And on the issue of our tax dollars being used to support abortion, the overwhelming majority of Americans, both male and female, Republican or Democrat, oppose the taxpayer funding of abortion. One recent poll found 75 percent oppose taxpayer funding of abortion.[1] The breakdown included 94 percent Republicans, 80 percent independents and 56 percent of Democrats. This is not a partisan issue for the American people.

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[1] Marist Poll, "Americans' Opinions on Abortion," January 2019 available at https://www.kofc.org/un/en/resources/communications/american-attitudes-abortion-knights-of-columbus-marist-poll-slides.pdf

The Trump Administration's recently finalized Protect Life Rule reflects the original intent of the Title X program and the American people's desires by delineating a bright line between abortion funding and Title X activities that ensures compliance with the program. For too long, the Title X program has been used as a slush fund for the abortion industry; this rule assures that comes to an end. Requiring physical and financial separation between Title X services and abortion is a common-sense rule that is desperately needed to ensure the program's integrity. This rule does not cut funding for family planning services by a dime but assures that Title X funds are directed in the way Congress and the American people intended.

At a time when we have seen many abortion providers embroiled in a plethora of scandals,[2] it is imperative that the federal government be proactive in their oversight of these programs. We urge you to uphold the law, stand with the values of the American people, and refuse the temptation to reduce this issue to partisan slogans.

Sincerely,

Penny Nance,
CEO & President

cc. House Committee on Energy & Commerce Members

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[2] See, "U.S. House of Representatives' Select Investigative Panel on Infant Lives Final Report," available at https://archives-energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/Select_Investigative_Panel_Final_Report.pdf; "Grassley Refers Planned Parenthood, Fetal Tissue Procurement Organizations to FBI, Justice Dept. for Investigation," available at https://www.grassley.senate.gov/news/news-releases/grassley-refers-planned-parenthood-fetal-tissue-procurement-organizations-fbi; International Planned Parenthood Federation (IPPF) accused of 'provid[ing] prostitutes for staff, donors and guests' attending official functions, available at https://www.dailymail.co.uk/news/article-7045455/British-sexual-health-charity-handed-132m-foreign-aid-provided-prostitutes-staff.html; "Institutional Dangerous Sex Promotion at Planned Parenthood," available at https://www.plannedparenthoodexposed.com/sexed/; "Denver lawsuit accuses abortion clinic of not reporting rape of 13-year-old," available at https://www.washingtontimes.com/news/2014/jul/11/denver-lawsuit-accuses-abortion-clinic-not-reporti/#ixzz3g1FL4FZh, etc.

June 18, 2019

The Honorable Gus Bilirakis
Representative
House of Representatives
2227 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Bilirakis,

Thank you for your continued work to protect taxpayer dollars from being used to subsidize the abortion industry. With a growing movement to repeal longstanding policies that regulate federal funding for abortion, it is important to support the Department of Health and Human Services final rule titled "Compliance with Statutory Program Integrity Requirements." The Title X statute passed in 1970 prohibits abortion from being used as a method of family planning. However, in 1993, President Bill Clinton issued regulations that co-mingle the Title X program with abortion providers and even require grantees to refer for abortions. We support the final rule issued by HHS because it ensures there will be a clear line drawn between family planning funds and the abortion industry.

Historically, the Title X regulations first implemented by President Ronald Reagan and continued by President George H.W. Bush enforced a clear separation of family planning funds and abortion by prohibiting Title X recipients from sharing a location with abortion services or from counseling or advocating for abortion.[1] The Supreme Court upheld these regulations in *Rust v. Sullivan* (1991) saying, "[I]f one thing is clear from the legislative history [of Title X], it is that Congress intended that Title X funds be kept separate and distinct from abortion-related activities."[2] President Bill Clinton later rescinded these regulations, in effect allowing Title X family planning providers to be co-located with abortion facilities. Consequently, for the past 25 years, Title X has not functioned as a mere family planning program like Congress intended. Instead, Title X has effectively subsidized the abortion industry because clinics that provide abortions can receive Title X funds to offset their other costs, even if no federal dollars are specifically funding abortion.

Of the $286.5 million appropriated to Title X, $60 million on average is sent to Planned Parenthood, making Title X grants the abortion chain's second largest funding stream. The new regulations address this problem by reinstating the Reagan Rule upheld in *Rust v. Sullivan* that ensures physical and financial separation between family planning clinics and abortion activities. Barring abortion clinics from sharing locations with family planning clinics will guarantee that federal funds are used in accordance with the law and not misused to support abortion.

Requiring Title X recipients to provide abortion referrals is also in direct violation of the Hyde-Weldon Amendment, which provides a conscience protection in federal law explicitly

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[1] *Federal Register* 53, no. 21 (February 2, 1988): 2944-2946, accessed online June 19, 2018, https://archive.org/stream/federalregister53aunit#page/n1694/mode/1up.
[2] *Rust v. Sullivan*, 500 U.S. 173 (1991), Opinion of the Court, accessed online June 19, 2018, https://www.law.cornell.edu/supct/html/89-1391.ZO.html.

designed to bar the use of federal funds by federal agencies that require the performance of abortions or referral for abortions against one's conscience.[3] Because of the abortion referral requirement which had been in place under previous administrations, pro-life groups and faith-based groups who have religious and moral objections to abortion could not qualify for Title X funds. Consequently, only those groups that are willing to refer for abortions had received funding. Under the new regulations issued by President Donald Trump, Title X can now be brought into accordance with conscience protections in federal law, specifically the Hyde-Weldon Amendment, by getting rid of the abortion referral requirement put in place by the Clinton administration.

It is important to note that not a single cent will be cut from the $286.45 million Congress has appropriated for the Title X Program. Removing the abortion referral requirement will enable faith-based and pro-life groups to apply for Title X funding without compromising their beliefs on abortion, thus increasing the diversity of family planning providers from which women can choose. The rule change will also encourage states who receive Title X funds to sub-grant money to organizations whose family planning options do not include abortion services. Federally Qualified Health Centers, Rural Health Centers, and Pregnancy Resource Centers are some of the health centers that may access family planning funds despite not offering abortion services or referrals, thus creating a broader array of family planning services available to women.

The final rule will not only eliminate government subsidizing of the abortion industry via the Title X program, but it will also emphasize that abortion is not a form of family planning, as the Title X statute states. Sixty percent of American voters do not want their tax dollars entangled with the abortion industry, and the new regulations maintain the federal government's neutral position on abortion funding. The Family Research Council will continue to support the steps taken by the Department of Health and Human Services to separate taxpayer funding from abortion services.

Sincerely,

Travis Weber
Vice President of Policy
Family Research Council

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[3] "Background: Hyde/Weldon Conscience Protection Amendment in the Labor/HHS Appropriations Bill" *USCCB.org*, Accessed online June 20, 2018, http://www.usccb.org/_cs_upload/7585_1.pdf.

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Congress of the United States
House of Representatives
Washington, DC 20515–1604

April 3, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

We write to express our strong support and deep thanks for the Department of Health and Human Services final rule titled, "Compliance with Statutory Program Integrity Requirements." Created by Congress in 1970, Title X of the Public Health Service Act authorized taxpayer funds to assist "voluntary family planning projects," and clearly prohibited federal funds from being awarded to abortion providers. The final rule fulfills both the spirit and letter of this decades-old law by once again separating abortion from family planning.

Regulations governing the Title X program had not been substantially updated since 2000. While previous regulations violated longstanding conscience laws and required all Title X recipients to refer for abortion, the final rule ensures that none of the funds appropriated for Title X may be used in programs where abortion is a method of family planning.[1] The elimination of the egregious abortion referral mandate appropriately protects the conscience rights of health care providers. Additionally, this allows providers previously unable to comply with the referral mandate to apply for Title X funding, therefore increasing the potential for diversity among providers within the program.

Furthermore, we strongly support the stipulation that Title X projects must be organized in such a way that there is complete physical and financial separation between a grantee's Title X activities and abortion activities. This much-needed reform will finally end the practice of "colocation," where abortions are conducted in the same facility as the Title X-funded family planning activities. This practice made federal funds vulnerable to misuse in support of abortion activities. It also implied that abortion was a method of family planning, in violation of Congressional intent.

Importantly, both elements – ending abortion referral and requiring the physical and financial separation of abortion activities within the program – were part of the regulations promulgated under President Ronald Reagan in 1988 and upheld by the Supreme Court in 1991.[2]

[1] 45 CFR 59.5
[2] Rust v. Sullivan, 500 US 173, (1991)

Additionally, we are grateful that the final rule no longer funnels taxpayer funded Title X dollars to support the work of abortion providers. Outdated rules allowed Planned Parenthood to receive $170 million from the Title X program, between 2013 and 2015, an average of nearly $60 million annually.[3] Planned Parenthood has already indicated that it will not comply with the final rule.[4] It has described its core mission as "providing, protecting and expanding access to abortion…," and Planned Parenthood has made the choice to reject Title X funds so that it can continue to perform abortions.[5] This funding can be redirected to family planning providers who do not prioritize an extreme abortion agenda over patient care. Redirecting this Title X funding stream is a significant step in continuing this administration's principled stand for lives of the unborn.

Not only is Planned Parenthood's unwavering support for taxpayer funded abortion our concern, but we remain concerned by a recent report that compiles several court cases, state health department reports, and testimonials from former Planned Parenthood employees, highlighting multiple instances where Planned Parenthood facilities across the country have repeatedly failed to report the suspected sexual abuse of minors in their care. The final rule addresses this issue by implementing a stronger focus on protecting women and children from being victimized by child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence and trafficking through annual staff training and site-specific protocol for reporting crime. We are also pleased that the final rule meaningfully encourages parental engagement and communication in family planning decision-making, while maintaining the confidential relationship between patients and medical professionals.

Lastly, the final rule updates and expands the review and scoring criteria applicable to grant applications. By restoring states' ability to prioritize funding according to the needs of their citizens, grantees can select clinical providers that meet the needs Title X needs of their patients.

The final rule takes great strides to restore the integrity of the Title X program by eliminating the mandate for Title X program participants to refer for abortion. We firmly disagree with using taxpayer dollars to subsidize abortion providers. Restoring a bright line of separation between family planning and abortion that is consistent with Congressional Intent to the Title X program is of vital importance to us. We will continue to support and defend the Department's work to guarantee that programs that use abortion as a method of family planning no longer receive Title X funding.

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[3] https://www.gao.gov/products/GAO-18-204R
[4] https://www.pbs.org/newshour/show/why-planned-parenthood-believes-title-x-rule-change-will-compromise-patient-health
[5] https://twitter.com/DrLeanaWen/status/1082660986513960966

Sincerely,

Ron Estes
Member of Congress

Vicky Hartzler
Member of Congress

Cathy McMorris Rodgers
Member of Congress

Virginia Foxx
Member of Congress

Jackie Walorski
Member of Congress

Ann Wagner
Member of Congress

Liz Cheney
Member of Congress

Martha Roby
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Patrick McHenry
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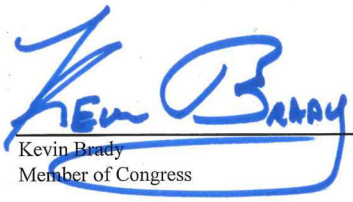
H. Morgan Griffith
Member of Congress



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Member of Congress

Rick W. Allen
Member of Congress

Steve Chabot
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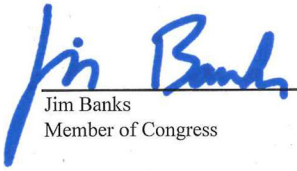
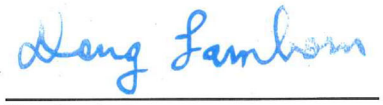
Adrian Smith
Member of Congress



Jim Banks
Member of Congress



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Tom Emmer
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James Comer
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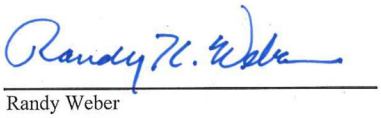
Andy Barr
Member of Congress



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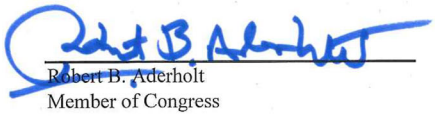
Member of Congress

Robert E. Latta
Member of Congress

Glenn Grothman
Member of Congress



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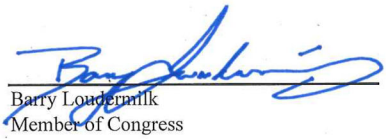
Andy Harris, M.D.
Member of Congress

David Kustoff
Member of Congress

David P. Roe, M.D.
Member of Congress

Gus M. Bilirakis
Member of Congress

Mike Kelly
Member of Congress



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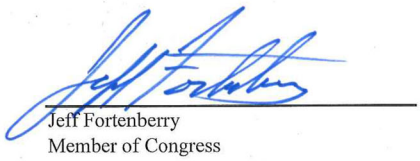
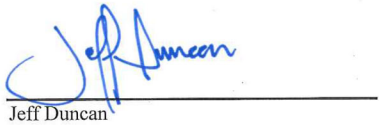
Andy Biggs
Member of Congress

Ralph Abraham, M.D.
Member of Congress

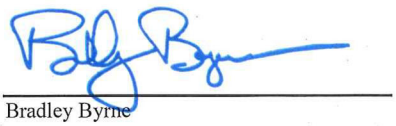
Mark Meadows
Member of Congress



Jeff Fortenberry
Member of Congress



Jeff Duncan
Member of Congress



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Robert J. Wittman
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Larry Bucshon, M.D.
Member of Congress

Tim Walberg
Member of Congress

Bruce Westerman
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Doug LaMalfa
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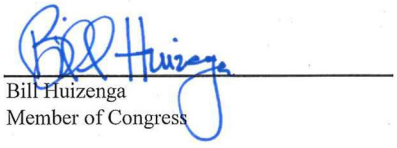
Bob Gibbs
Member of Congress

Duncan Hunter
Member of Congress

Jason Smith
Member of Congress



Bill Huizenga
Member of Congress

Bill Johnson
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Brian Babin
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Pete Olson
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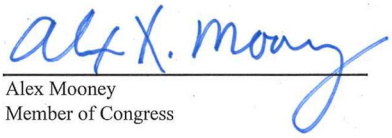
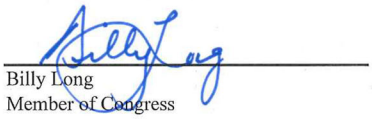


Alex Mooney
Member of Congress

Brett Guthrie
Member of Congress



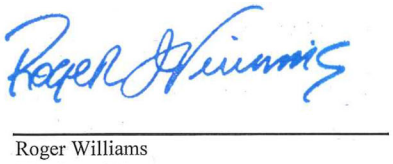
Billy Long
Member of Congress

John Ratcliffe
Member of Congress

Don Bacon
Member of Congress

Trent Kelly
Member of Congress

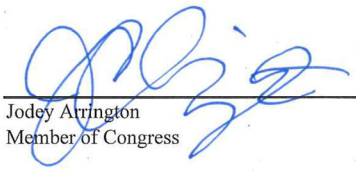
Ralph Norman
Member of Congress



Roger Williams
Member of Congress

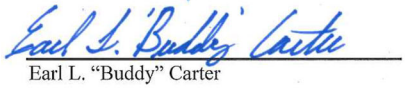
Sam Graves
Member of Congress

Tom Graves
Member of Congress



Jodey Arrington
Member of Congress

Mark Walker
Member of Congress

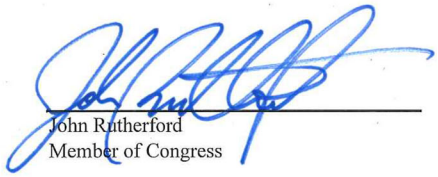


Earl L. "Buddy" Carter
Member of Congress

Jim Jordan
Member of Congress

Michael C. Burgess, M.D.
Member of Congress

Steven Palazzo
Member of Congress



John Rutherford
Member of Congress

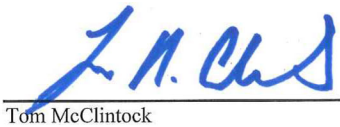
Jody Hice
Member of Congress

Matt Gaetz
Member of Congress

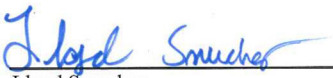
Blaine Luetkemeyer
Member of Congress

Steve King
Member of Congress

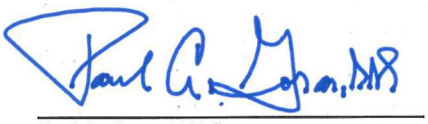
Chris Stewart
Member of Congress



Tom McClintock
Member of Congress



Lloyd Smucker
Member of Congress



Paul A. Gosar, D.D.S.
Member of Congress

Rob Bishop
Member of Congress

Troy Balderson
Member of Congress

Roger Marshall, M.D.
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Ben Cline
Member of Congress

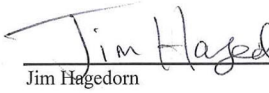
Kenny Marchant
Member of Congress

Russ Fulcher
Member of Congress

Lance Gooden
Member of Congress

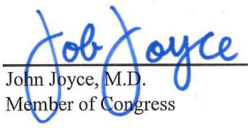
Mark Green
Member of Congress

Michael Guest
Member of Congress



Jim Hagedorn
Member of Congress

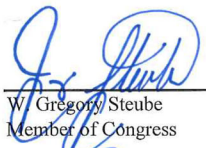
Kevin Hern
Member of Congress



John Joyce, M.D.
Member of Congress

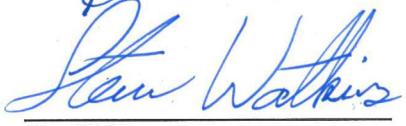
Debbie Lesko
Member of Congress

Bryan Steil
Member of Congress

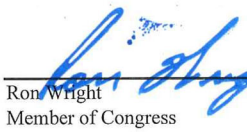


W. Gregory Steube
Member of Congress

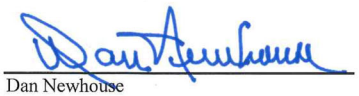
William R. Timmons, IV
Member of Congress



Steve Watkins
Member of Congress



Ron Wright
Member of Congress



Dan Newhouse
Member of Congress

Congress of the United States
Washington, DC 20515

April 30, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

The Title X Family Planning Program is in dire need of review and updated regulations that ensure program integrity with respect to elective abortion. Authorized in 1970, the program is intended to assist in "voluntary family planning projects," offering "a broad range of acceptable and effective family planning methods and services," and may not fund "programs where abortion is a method of family planning."[1] The regulations governing this program have been largely unchanged for nearly two decades and are sorely in need of reform.

While the authorizing statute drew a bright line between family planning and abortion, the regulations governing the Title X program have blurred that line by requiring all grantees to refer for abortion.[2] This mandate has deterred program applicants who do not consider abortion to be a method of family planning. It also runs counter to the program's statutory prohibition on funding programs "where abortion is a method of family planning."[3] New regulations should remove abortion referrals from the program.

The separation between abortion and family planning has further been weakened by permitting Title X clinics to be "co-located" within the same facility as an entity that provides abortion. In these instances, the location of the Title X service site, as listed in the 2018 Office of Population Affairs Directory, is also the location of a Planned Parenthood abortion clinic. Such an arrangement raises concerns about program integrity. Co-located centers may be vulnerable to misuse of funds in support of abortion activities and send a message that abortion is considered a method of family planning in federally funded family planning programs. To ensure that the federally funded family planning services offered by Title X grant recipients are unquestionably separate and distinct from abortion, Title X service sites should be physically, as well as financially, separate from facilities that provide abortion.

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[1] 42USC, 300
[2] 42 CFR 59.5
[3] 42 USC, 300a-6

Our requests are not unprecedented. In 1991, the Supreme Court upheld Title X regulations issued in 1988 by the Reagan Administration to set a standard of compliance with the statutory requirement that none of the funds appropriated under Title X may be used in programs where abortion is a method of family planning.[4] Those regulations required, in part, the physical separation of abortion activities from Title X service sites, and did not permit grantees to make abortion referrals.

In conclusion, we must note our deep concern over a recent GAO report, which found that, between 2013 and 2015, Planned Parenthood received $170 million from the Title X program, an average of nearly $60 million annually.[5] This Congress has made multiple attempts to divest taxpayers from being forced to underwrite Planned Parenthood, the nation's largest abortion provider. Planned Parenthood has described abortion as "a necessary service that's as vital to our mission as birth control..."[6] It is time for the Title X funding stream for Planned Parenthood to be turned off.

We urge you to move swiftly to issue regulations for the Title X program that will stop funding for programs where abortion is a method of family planning.

Sincerely,

Ron Estes
Member of Congress

Vicky Hartzler
Member of Congress

Diane Black
Member of Congress

Christopher H. Smith
Member of Congress

[4] *Rust v. Sullivan*, 500 US 173, (1991)
[5] https://www.gao.gov/products/GAO-18-204R
[6] https://twitter.com/CecileRichards/status/838870624097419270

Virginia Foxx
Member of Congress

Cathy McMorris Rogers
Member of Congress

Kristi Noem
Member of Congress

Lynn Jenkins, CPA
Member of Congress

Ann Wagner
Member of Congress

Jackie Walorski
Member of Congress

Jaime Herrera Beutler
Member of Congress

Marsha Blackburn
Member of Congress

Martha Roby
Member of Congress

Liz Cheney
Member of Congress

Mia Love
Member of Congress

Morgan Griffith
Member of Congress

Kevin McCarthy, Majority Leader
Member of Congress

Steve Scalise, Majority Whip
Member of Congress

Patrick McHenry, Chief Deputy Whip
Member of Congress

Kevin Brady
Member of Congress

Bob Goodlatte
Member of Congress

Bill Shuster
Member of Congress

Gregg Harper
Member of Congress

Steve Chabot
Member of Congress

Doug Lamborn
Member of Congress

Jim Banks
Member of Congress

David B. McKinley, P.E
Member of Congress

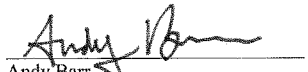
James Comer
Member of Congress

John Culberson
Member of Congress

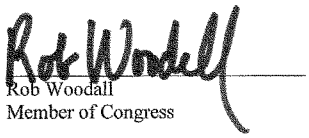
Warren Davidson
Member of Congress

Steve King
Member of Congress

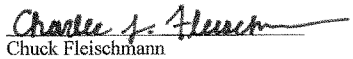
Randy Weber
Member of Congress



Andy Barr
Member of Congress



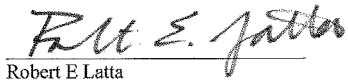
Rob Woodall
Member of Congress



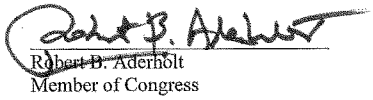
Chuck Fleischmann
Member of Congress

Glenn Grothman
Member of Congress

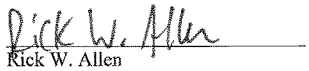
Luke Messer
Member of Congress



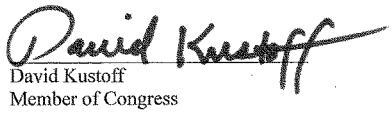
Robert E Latta
Member of Congress



Robert B. Aderholt
Member of Congress



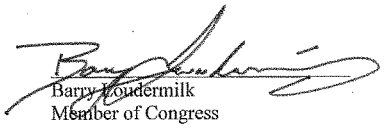
Rick W. Allen
Member of Congress



David Kustoff
Member of Congress

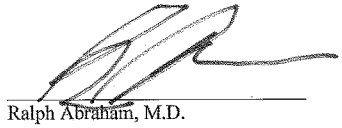
Adrian Smith
Member of Congress

Gus M. Bilirakis
Member of Congress

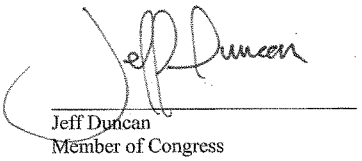


Barry Loudermilk
Member of Congress

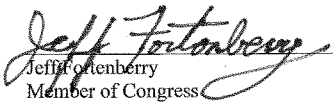
Mark Meadows
Member of Congress



Ralph Abraham, M.D.
Member of Congress



Jeff Duncan
Member of Congress



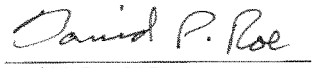
Jeff Fortenberry
Member of Congress

Bradley Byrne
Member of Congress

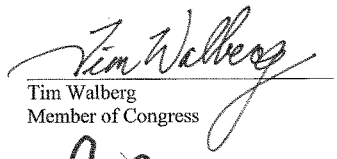
Andy Harris
Member of Congress

Robert J. Wittman
Member of Congress

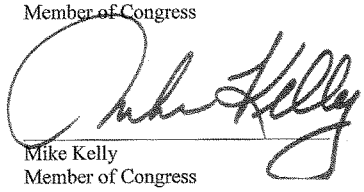
Francis Rooney
Member of Congress



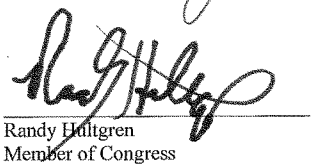
David P. Roe, M.D.
Member of Congress



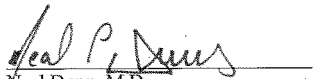
Tim Walberg
Member of Congress



Mike Kelly
Member of Congress



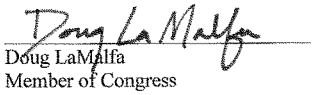
Randy Hultgren
Member of Congress



Neal Dunn, M.D.
Member of Congress

Garret Graves
Member of Congress

Joe Wilson
Member of Congress



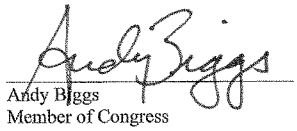
Doug LaMalfa
Member of Congress

Richard Hudson
Member of Congress

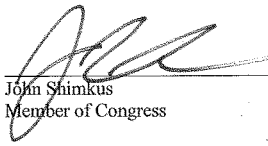
Ted Poe
Member of Congress

Steve Pearce
Member of Congress

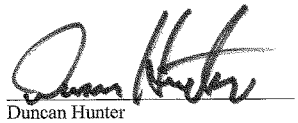
Paul Mitchell
Member of Congress



Andy Biggs
Member of Congress



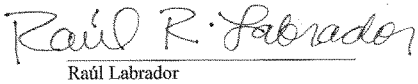
John Shimkus
Member of Congress



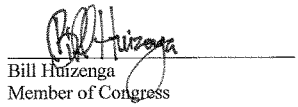
Duncan Hunter
Member of Congress

Daniel W. Lipinski
Member of Congress

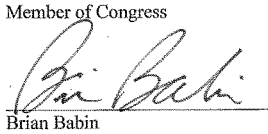
K. Michael Conaway
Member of Congress



Raúl Labrador
Member of Congress



Bill Huizenga
Member of Congress



Brian Babin
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Jack Bergman
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Bill Flores
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Ted S. Yoho, DVM
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Larry Bucshon, M.D.
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Ted Budd
Member of Congress

Dana Rohrabacher
Member of Congress

Clay Higgins
Member of Congress

Daniel Webster
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Mike Bost
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Bruce Westerman
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Michael T. McCaul
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Todd Rokita
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Brett Guthrie
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Jim Renacci
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Bob Gibbs
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David Rouzer
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John Ratcliffe
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Peter Roskam
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Robert Pittenger
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Keith Rothfus
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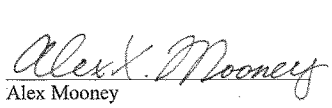
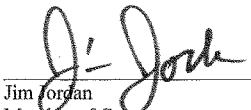
A. Drew Ferguson, IV DMD
Member of Congress

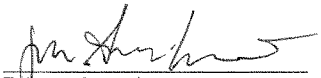


Alex Mooney
Member of Congress

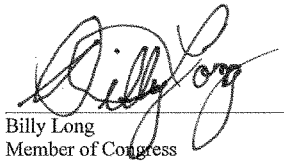


Jim Jordan
Member of Congress

Dave Brat
Member of Congress

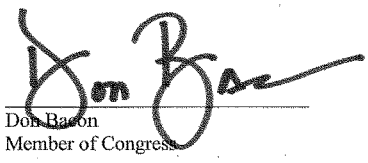


F. James Sensenbrenner, Jr.
Member of Congress



Billy Long
Member of Congress

Steven Palazzo
Member of Congress



Don Bacon
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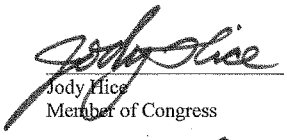
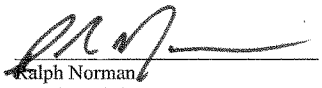


Jody Hice
Member of Congress



Ralph Norman
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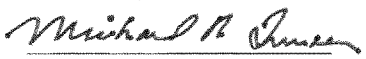
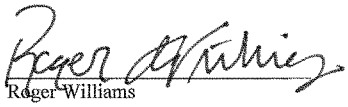
Sam Graves
Member of Congress

Ken Buck
Member of Congress

Ron DeSantis
Member of Congress

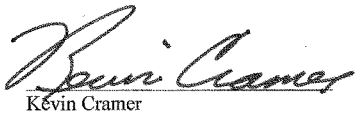


Michael Turner
Member of Congress



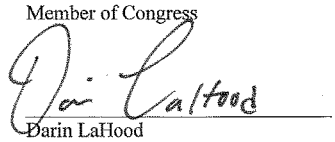
Roger Williams
Member of Congress

Steve Russell
Member of Congress



Kevin Cramer
Member of Congress

Roger Marshall, M.D.
Member of Congress



Darin LaHood
Member of Congress

Tom Graves
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Sean Duffy
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Scott DeJarlais
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Rick Crawford
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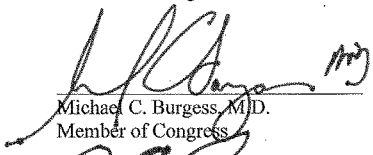
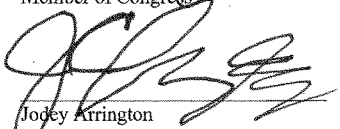
Earl L. "Buddy" Carter
Member of Congress

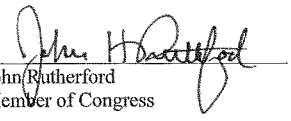


Michael C. Burgess, M.D.
Member of Congress

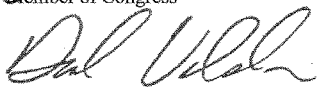
Greg Gianforte
Member of Congress



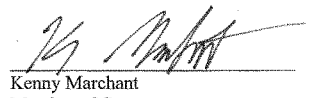
Jodey Arrington
Member of Congress



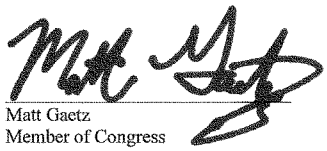
John Rutherford
Member of Congress



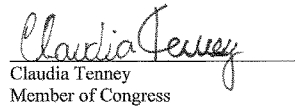
David Valadao
Member of Congress



Kenny Marchant
Member of Congress

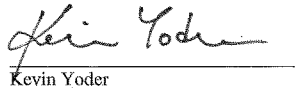


Matt Gaetz
Member of Congress

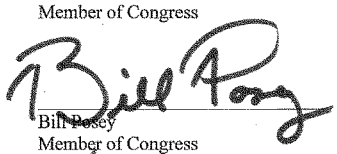


Claudia Tenney
Member of Congress

Tom Cole
Member of Congress



Kevin Yoder
Member of Congress



Bill Posey
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Evan Jenkins
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Austin Scott
Member of Congress

Tom Emmer
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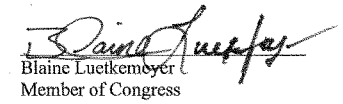
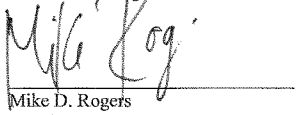
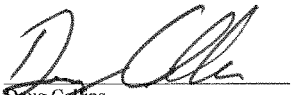


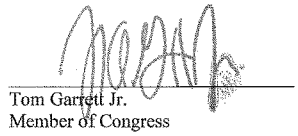
Blaine Luetkemeyer
Member of Congress



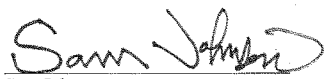
Mike D. Rogers
Member of Congress



Doug Collins
Member of Congress



Tom Garrett Jr.
Member of Congress



Sam Johnson
Member of Congress

Mike Bishop
Member of Congress

Gary Palmer
Member of Congress

Lou Barletta
Member of Congress

Tom McClintock
Member of Congress

Chris Stewart
Member of Congress

Paul Gosar
Member of Congress

Lloyd Smucker
Member of Congress

Jeb Hensarling
Member of Congress

Rodney Davis
Member of Congress

Mike Johnson
Member of Congress

Walter B. Jones
Member of Congress

Congress of the United States
Washington, DC 20515

July 10, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar,

We write to express our strong support and deep thanks for the Department of Health and Human Services proposed rule titled, "Compliance with Statutory Program Integrity Requirements." Created by Congress in 1970, Title X of the Public Health Service Act authorized taxpayer funds to assist "voluntary family planning projects," and clearly prohibited federal funds from being spent in "programs where abortion is a method of family planning." The proposed rule fulfills both the spirit and letter of this decades-old law by separating abortion from family planning.

Current program regulations require all Title X recipients to refer for abortion, in contradiction of longstanding conscience laws intended to protect against abortion discrimination.[1] For instance, the Weldon Amendment protects health care providers who choose not to participate in abortion from discrimination by "a federal agency or program." The Title X program has not been updated since the Weldon Amendment was first approved by Congress in 2005 (it has been re-affirmed annually since that time, most recently in P.L. 115-141.)[2] As they stand now, Title X regulations are contrary to federal law and in dire need of the proposed update.

The proposed rule appropriately eliminates the egregious abortion referral mandate. By protecting the conscience rights of health care providers, the Department's revision increases the potential for diversity among providers within the program. It allows providers previously unable to comply with the referral mandate to apply for Title X funding.

We strongly support the proposed rule's clarification that "a Title X project may not perform, promote, refer for, or support, abortion as a method of family planning." While critics of the proposed rule claim it will restrict conversations between health care providers and patients, the rule does not prohibit nondirective counseling. Reflecting the statutory intention that Title X funds may only be used for family planning, once a Title X client is pregnant, the proposed rule advises that she "shall be given assistance with setting up a referral appointment to optimize the health of mother and unborn child."

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[1] 45 CFR 59.5
[2] The Weldon Amendment was included in H.R. 1625, the Consolidated Appropriations Act, 2018, which became Public Law 115-141 on March 23, 2018.

The proposed rule stipulates that Title X projects must be organized in such a way that there is complete physical and financial separation between a grantee's Title X activities and abortion activities. This much-needed reform will finally end the practice of "colocation," where abortions are conducted in the same facility as the Title X-funded family planning activities. This practice made federal funds vulnerable to misuse in support of abortion activities. It also implied that abortion was a method of family planning, in violation of Congressional intent.

Importantly, both elements -- ending abortion referral and requiring the physical and financial separation of abortion activities within the program -- were part of the regulations promulgated under President Ronald Reagan in 1988 and upheld by the Supreme Court in 1991.[3]

Additionally, the proposed rule increases Title X program accountability and oversight in cases of suspected sexual abuse of minors. We are deeply concerned by a recent report that compiles several court cases, state health department reports, and testimonials from former Planned Parenthood employees, highlighting multiple instances where Planned Parenthood facilities across the country have repeatedly failed to report the suspected sexual abuse of minors in their care. Planned Parenthood is a significant recipient of Title X grant awards; according to a 2018 GAO report the organization expended approximately $56 million annually from Title X between 2013 and 2015.[4] The documented instances of Planned Parenthood's complicity in child sexual abuse suggests that the Department needed to strengthen protections for victims of sexual abuse being served at Title X clinics.

Since 1999, Congress has annually approved language intended to clarify that Title X entities are not exempt from state reporting laws on child abuse, child molestation, sexual abuse, rape or incest.[5] However, Title X regulations have not been updated since that time to reflect Congress's concern in this area. Therefore, we commend the Department for taking steps in the proposed rule to bolster its oversight of grantee compliance with state abuse reporting requirements, notably making such compliance a condition of continued grant funding. Further, while respecting Title X's commitment to patient confidentiality, the proposed rule clarifies that confidentiality "may not be used as a rationale for noncompliance with laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, human trafficking, or similar reporting laws." We are grateful for these important steps to protect minors who may be the victims of sexual abuse.

Through annual appropriations Congress has also instructed Title X that potential grantees must certify that they encourage family participation when minors seek family planning services.[6] The proposed rule responds to Congressional intent and finally makes this provision a requirement within the regulations for program grantees.

In sum, this proposed rule restores to the Title X program a bright line of separation between family planning and abortion that is consistent with Congressional intent. We urge the Department to promptly finalize the proposed rule.

Sincerely,

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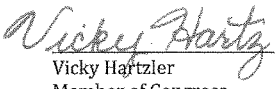
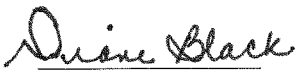
[3] Rust v. Sullivan, 500 US 173, (1991)
[4] https://www.gao.gov/products/GAO-18-204R
[5] This language was most recently included in H.R. 1625, the Consolidated Appropriations Act, 2018, which became Public Law 115-141 on March 23, 2018.
[6] H.R. 1625, the Consolidated Appropriations Act, 2018, which became Public Law 115-141 on March 23, 2018.

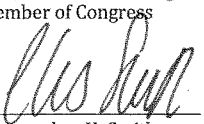
Ron Estes
Member of Congress



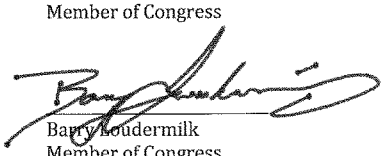
Vicky Hartzler
Member of Congress



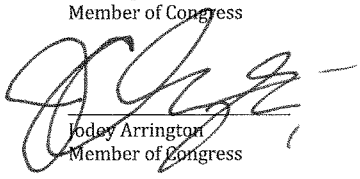
Diane Black
Member of Congress



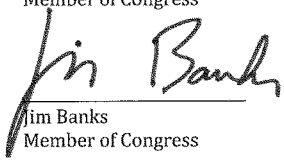
Christopher H. Smith
Member of Congress



Barry Loudermilk
Member of Congress

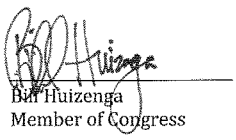


Jodey Arrington
Member of Congress

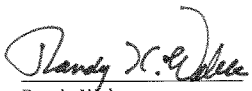


Jim Banks
Member of Congress

Mark Walker
Member of Congress



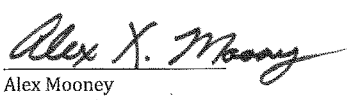
Bill Huizenga
Member of Congress



Randy Weber
Member of Congress

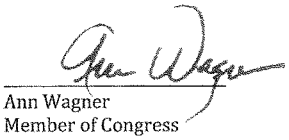
David Rouzer
Member of Congress

Mike Johnson
Member of Congress



Alex Mooney
Member of Congress

Doug Lamborn
Member of Congress



Ann Wagner
Member of Congress

Kevin Yoder
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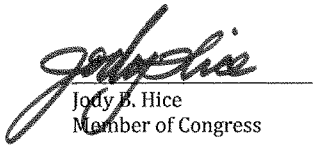
Dennis A. Ross
Member of Congress



Jody B. Hice
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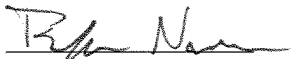
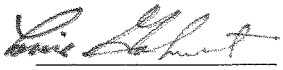
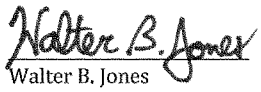


Ralph Norman
Member of Congress

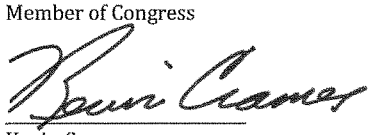


Louie Gohmert
Member of Congress

Jack Bergman
Member of Congress



Walter B. Jones
Member of Congress



Kevin Cramer
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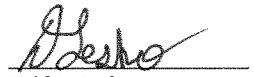
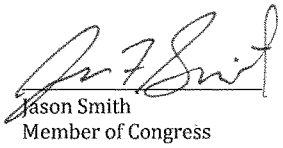
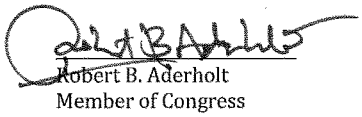


Debbie Lesko
Member of Congress

Andy Harris
Member of Congress



Jason Smith
Member of Congress



Robert B. Aderholt
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Warren Davidson
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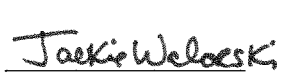
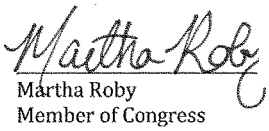


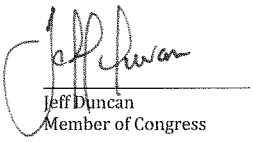
Jackie Walorski
Member of Congress



Martha Roby
Member of Congress

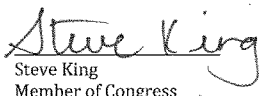
Gus M. Bilirakis
Member of Congress

Bruce Westerman
Member of Congress

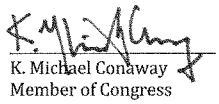


Jeff Duncan
Member of Congress

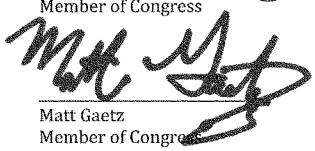
Steve Scalise
Member of Congress



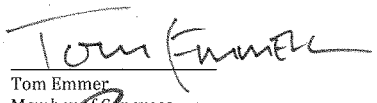
Steve King
Member of Congress



K. Michael Conaway
Member of Congress

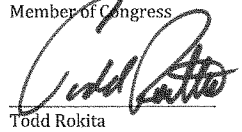


Matt Gaetz
Member of Congress

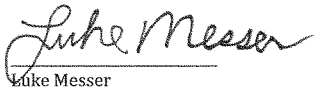


Tom Emmer
Member of Congress

Glenn Grothman
Member of Congress



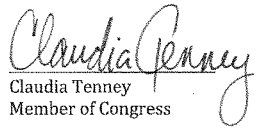
Todd Rokita
Member of Congress



Luke Messer
Member of Congress

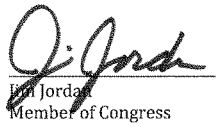
Doug LaMalfa
Member of Congress

Lou Barletta
Member of Congress

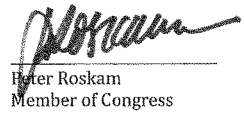


Claudia Tenney
Member of Congress

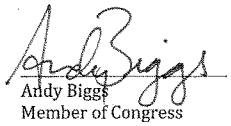
Daniel Webster
Member of Congress



Jim Jordan
Member of Congress



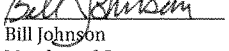
Peter Roskam
Member of Congress



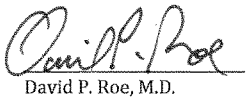
Andy Biggs
Member of Congress

Randy Hultgren
Member of Congress

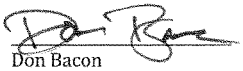
Mike Kelly
Member of Congress



Bill Johnson
Member of Congress



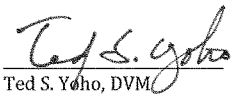
David P. Roe, M.D.
Member of Congress



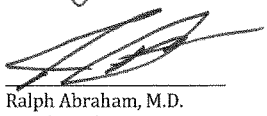
Don Bacon
Member of Congress

Cathy McMorris Rodgers
Member of Congress

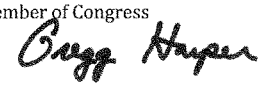
Larry Bucshon, M.D.
Member of Congress



Ted S. Yoho, DVM
Member of Congress

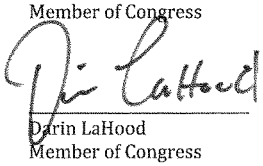


Ralph Abraham, M.D.
Member of Congress

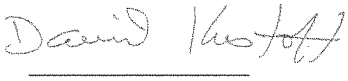


Gregg Harper
Member of Congress

Pete Olson
Member of Congress

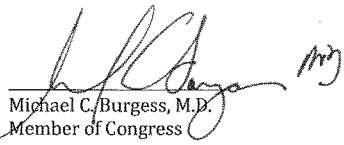


Darin LaHood
Member of Congress



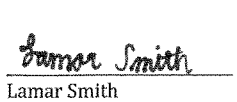
David Kustoff
Member of Congress

Jim Renacci
Member of Congress



Michael C. Burgess, M.D.
Member of Congress

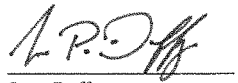
James Comer
Member of Congress



Lamar Smith
Member of Congress

Keith Rothfus
Member of Congress

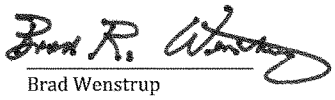
Lloyd Smucker
Member of Congress



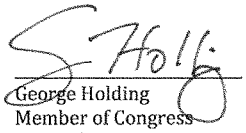
Sean Duffy
Member of Congress

Paul Mitchell
Member of Congress

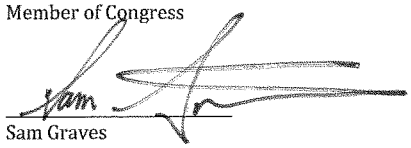
Rob Bishop
Member of Congress



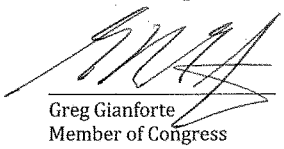
Brad Wenstrup
Member of Congress



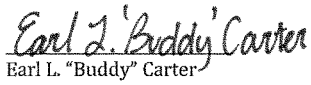
George Holding
Member of Congress



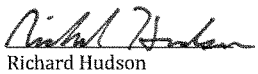
Sam Graves
Member of Congress



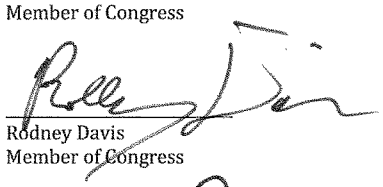
Greg Gianforte
Member of Congress



Earl L. "Buddy" Carter
Member of Congress

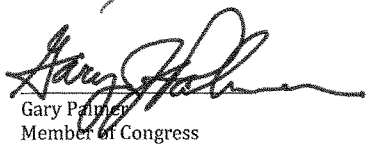


Richard Hudson
Member of Congress

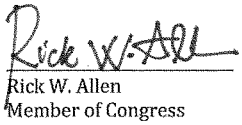


Rodney Davis
Member of Congress

Adrian Smith
Member of Congress

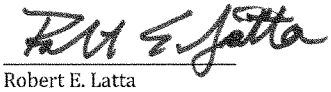


Gary Palmer
Member of Congress

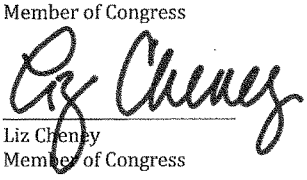


Rick W. Allen
Member of Congress

Bob Gibbs
Member of Congress



Robert E. Latta
Member of Congress

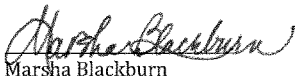


Liz Cheney
Member of Congress

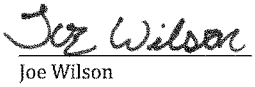
Kenny Marchant
Member of Congress

John Rutherford
Member of Congress

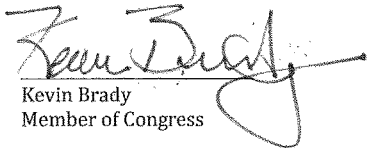
Ron DeSantis
Member of Congress



Marsha Blackburn
Member of Congress

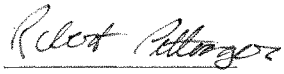


Joe Wilson
Member of Congress



Kevin Brady
Member of Congress

Steve Chabot
Member of Congress

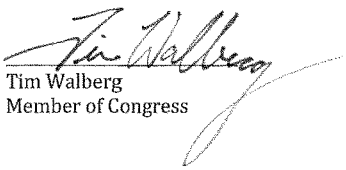


Robert Pittenger
Member of Congress

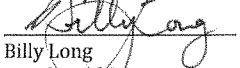
Brian Babin
Member of Congress

Dave Brat
Member of Congress

Bill Shuster
Member of Congress



Tim Walberg
Member of Congress

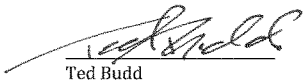


Billy Long
Member of Congress

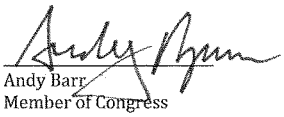
Mark Meadows
Member of Congress

Roger Marshall, M.D.
Member of Congress

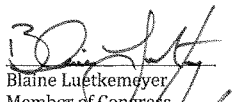
Bradley Byrne
Member of Congress



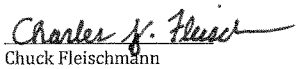
Ted Budd
Member of Congress



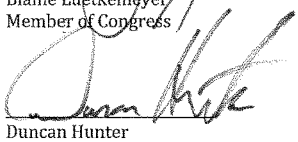
Andy Barr
Member of Congress



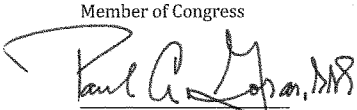
Blaine Luetkemeyer
Member of Congress



Chuck Fleischmann
Member of Congress



Duncan Hunter
Member of Congress



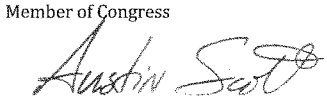
Paul A. Gosar, D.D.S
Member of Congress

Chris Stewart
Member of Congress

David G. Valadao
Member of Congress

Ken Buck
Member of Congress

Bill Flores
Member of Congress



Austin Scott
Member of Congress

Sam Johnson
Member of Congress

Michael R. Turner
Member of Congress

Francis Rooney
Member of Congress

Jaime Herrera Beutler
Member of Congress

Adam Kinzinger
Member of Congress

Daniel W. Lipinski
Member of Congress

Jeb Hensarling
Member of Congress

Virginia Foxx
Member of Congress

Clay Higgins
Member of Congress

Tom McClintock
Member of Congress

Kristi Noem
Member of Congress

Roger Williams
Member of Congress

Michael T. McCaul
Member of Congress

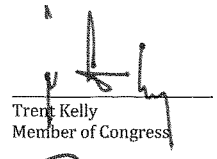
Collin C. Peterson
Member of Congress

Brett Guthrie
Member of Congress

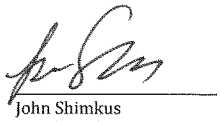
Mike Bishop
Member of Congress

Steven Palazzo
Member of Congress

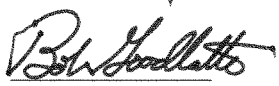
Jeff Fortenberry
Member of Congress



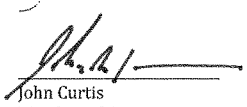
Trent Kelly
Member of Congress



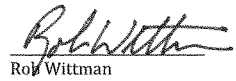
John Shimkus
Member of Congress



Bob Goodlatte
Member of Congress

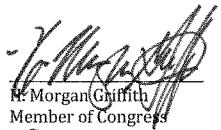


John Curtis
Member of Congress

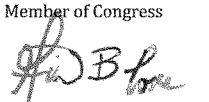


Rob Wittman
Member of Congress

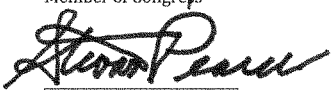
Tom Graves
Member of Congress



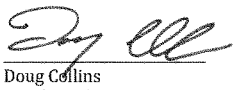
H. Morgan Griffith
Member of Congress



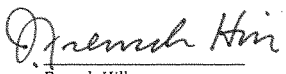
Mia Love
Member of Congress



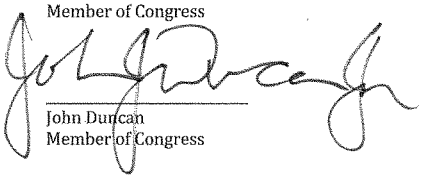
Steve Pearce
Member of Congress



Doug Collins
Member of Congress



French Hill
Member of Congress



John Duncan
Member of Congress

The Final Title X Regulation Disregards Expert Opinion and Evidence-Based Practices

February 26, 2019

Washington, D.C. – The Department of Health and Human Services has released a final regulation that will significantly limit the health care available to patients under Title X of the Public Health Service Act (Title X). Leading women's health care provider groups, medical organizations, and physician leaders representing more than 4.3 million health care providers are alarmed by the new regulation which disregards the expertise of the medical and scientific community and evidence-based standards.

"As the only federal program exclusively dedicated to providing low-income patients, including adolescents, with access to family planning and preventive health services and information, Title X plays a vital role in the fabric of America's family planning safety net. The final regulation is the latest of numerous recent decisions—from rolling back insurance coverage for contraceptives to attempting to eliminate funding for evidence-based teen pregnancy prevention programs—that unravel the threads of this safety net. Together, these decisions compound, leaving women and families with increasingly fewer options for obtaining medically accurate, affordable, and timely access to contraception and preventive care.

"The new regulation weakens existing standards requiring that family planning programs funded through Title X offer a range of evidence-based contraception options. It also conditions federal funding for family planning services on a requirement that providers omit certain information in counseling patients and seeks to exclude qualified providers from Title X.

"This regulation will do indelible harm to the health of Americans and to the relationship between patients and their providers. By forcing providers to omit critical information about health care and resources available, the final regulation directly undermines patients' confidence in their care.

"There is no room for politics in the exam room. For the health of the American people, every individual must have access to comprehensive, affordable care in a safe and timely fashion, just as every provider must be able to deliver medically accurate information and care. The administration should retract this regulation and consider the record volume of comments from the medical, scientific, and patient advocacy communities. Family planning policy should be driven by facts, evidence, and necessity, not politics and ideology."

The American College of Obstetricians and Gynecologists
The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization of more than 58,000 members, ACOG strongly advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. www.acog.org

The American Academy of Pediatrics
The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, www.aap.org and follow us on Twitter @AmerAcadPeds.

The American College of Nurse-Midwives
The American College of Nurse-Midwives (ACNM) is the professional association that represents certified nurse-midwives (CNMs) and certified midwives (CMs) in the United States. With roots dating to 1929, ACNM sets the standard for excellence in midwifery education and practice in the United States and strengthens the capacity of midwives in developing countries. ACNM's members are primary care providers for women throughout the

lifespan, with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health. Visit www.midwife.org to learn more or follow ACNM on Twitter or Facebook.

The American College of Osteopathic Obstetricians and Gynecologists
Founded in 1934, the American College of Osteopathic Obstetricians and Gynecologists is a nonprofit, nonpartisan organization committed to excellence in women's health. The purpose of the ACOOG is to educate and support osteopathic physicians to improve the quality of life for women by promoting programs that are innovative, visionary, inclusive, and socially relevant. The ACOOG is likewise committed to being the premier leader in the physical, emotional, and spiritual health of women.

The American College of Physicians
The American College of Physicians is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. ACP membership includes 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Follow ACP on Twitter and Facebook.

The American Nurses Association
The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 4 million registered nurses. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving the quality of health care for all. For more information, visit www.nursingworld.org.

The American Psychiatric Association
The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 38,500 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information please visit www.psychiatry.org.

The American Society for Reproductive Medicine
ASRM is a multidisciplinary organization dedicated to the advancement of the science and practice of reproductive medicine. The Society accomplishes its mission through the pursuit of excellence in education and research and through advocacy on behalf of patients, physicians, and affiliated health care providers. The Society is committed to facilitating and sponsoring educational activities for the lay public and continuing medical education activities for professionals who are engaged in the practice of and research in reproductive medicine. www.asrm.org

The American Urogynecologic Society
The American Urogynecologic Society (AUGS) is the premier non-profit organization representing professionals dedicated to treating female pelvic floor disorders. Founded in 1979, AUGS represents more than 1,900 members, including practicing physicians, nurse practitioners, physical therapists, nurses and health care professionals, and researchers from many disciplines. For members and constituents, AUGS is the primary source of clinical and scientific information and education in Female Pelvic Medicine and Reconstructive Surgery (FPMRS).

The Association for Physician Assistants in Obstetrics and Gynecology
The Association for Physician Assistants in Obstetrics and Gynecology (APAOG) is the only professional association devoted exclusively to PAs practicing in women's health. Established in 1991, APAOG is the collective voice for professionals working to improve the health care of women. APAOG is a voluntary, nonprofit organization committed to improving women's health through advocating for patient autonomy through education and collaborative care, promoting clinical and academic excellence for APAOG members, and to assist and support PA's and the healthcare team by delivering the highest quality women's healthcare services. www.apaog.org

The Association of Women's Health, Obstetric and Neonatal Nurses
Since 1969, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has been the foremost authority promoting the health of women and newborns and strengthening the nursing profession through the delivery of superior advocacy, research, education, and other professional and clinical resources. AWHONN represents the interests of 350,000 registered nurses working in women's health, obstetric, and neonatal nursing across the United States. Learn more about AWHONN at www.awhonn.org.

The North American Society for Pediatric and Adolescent Gynecology
The North American Society for Pediatric and Adolescent Gynecology (NASPAG), founded in 1986, is dedicated to providing multidisciplinary leadership in education, research and gynecologic care to improve the reproductive health of youth. Its focus is to serve and be recognized as the lead provider in PAG education, research and clinical care, conduct and encourage multidisciplinary and inter-professional programs of medical education and research in the field of PAG, and advocate for the reproductive well-being of children and adolescents and the

provision of unrestricted, unbiased and evidence based practice of PAG. Its official journal, Journal of Pediatric and Adolescent Gynecology, had its first volume published in 1987 and it continues to cover the spectrum of basic science and clinical research in the subspecialty area, addressing gynecological related problems from birth through early twenties. The Society continues to grow in membership as it serves to inform, educate and advance the quality of care for young gynecological patients both nationally and internationally.

The National Association of Nurse Practitioners in Women's Health
The National Association of Nurse Practitioners in Women's Health (NPWH) is a nonprofit, professional membership association representing more than 8,000 Women's Health Nurse Practitioners (WHNPs). Advanced practice registered nurses and other healthcare providers rely on NPWH for resources and education that improve women's health and wellness through evidence-based practice. NPWH pioneers policies to address gender disparities and forges strategic partnerships that advance health equity and holistic models of care. For more information, visit www.npwh.org

Nurses for Sexual and Reproductive Health
NSRH is a national grassroots organization dedicated to providing students, nurses and midwives with education and resources to become skilled care providers and social change agents in sexual and reproductive health and justice. For more information visit http://nsrh.org/.

The Society for Adolescent Health and Medicine
Founded in 1968, the Society for Adolescent Health and Medicine is a multidisciplinary organization of over 1,200 members committed to improving the physical and psychosocial health and well-being of all adolescents and young adults through advocacy, clinical care, health promotion, health service delivery, professional development and research.

The Society for Academic Specialists in General Obstetrics and Gynecology
The Society for Academic Specialists in General Obstetrics and Gynecology seeks to enhance women's health by supporting academic generalist physicians in all phases of their careers. Our goal is to support education and scholarship, while fostering excellence in research.

The Society for Maternal-Fetal Medicine
The Society for Maternal-Fetal Medicine (SMFM) is a non-profit, membership organization based in Washington, DC. With more than 3,500 physicians, scientists and women's health professionals around the world, the Society supports the clinical practice of maternal-fetal medicine by providing education, promoting research and engaging in advocacy to optimize the health of high-risk pregnant women and their babies. SMFM hosts an annual scientific meeting in which new ideas and research related to high-risk pregnancies are unveiled and discussed. For more information, visit www.smfm.org.

The Society of Family Planning
The Society of Family Planning (SFP) strives for just and equitable abortion and contraception, which is informed by science. We believe science is an essential, though under-utilized tool for improving the delivery of, and access to, evidence-based abortion and contraception care and for aligning policy and practice with the best available evidence.

The Society of Gynecologic Oncology
The Society of Gynecologic Oncology (SGO) is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. As a 501(c)(6) organization, the SGO contributes to the advancement of women's cancer care by encouraging research, providing education, raising standards of practice, advocating for patients and members and collaborating with other domestic and international organizations.

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"Protecting Title X and Safeguarding Quality Family Planning Care"

June 19, 2019

Dr. Diane Foley, Deputy Assistant Secretary, Office of Population Affairs, U.S. Department of Health and Human Services

The Honorable Frank Pallone, Jr. (D-NJ)

1. Planned Parenthood affiliates, who have served 40% of the approximately four million Title X patients each year, as well as Maine Family Planning and multiple states have all indicated they will no longer participate in the program under the new Title X rule now in effect. Given that a March 2018 Kaiser Family Foundation study based on a nationwide survey of community health centers found that a majority of health centers are unable to accept a major increase in new patients, what entities does OPA believe will serve these 1.6 or more new patients seeking quality family planning care?

   Response: As the Office of Population Affairs has endeavored to bring competition and diversity to its grantees and to incentivize grantees and applicants to provide family planning services to people in unserved and underserved areas (including rural areas), the number of Planned Parenthood grantees has declined. Other types of Title X clinics include public health departments, Federally Qualified Health Centers (FQHCs), hospital sites, as well as other independent clinics not affiliated with Planned Parenthood. Many FQHCs already provide family planning services and have indicated they have the ability to increase capacity and provide Title X services.

   In addition, the Final Rule encourages diverse and new organizations to serve patients in the Title X program. Community health organizations, clinics, and hospitals that are currently not Title X grantees or subrecipients could seek to participate in the Title X program – and could easily serve patients seamlessly since they already are committed to providing medical care to women and men in their communities and many already provide family planning services to their patients.

2. As of a briefing with my staff on June 14, 2019, you confirmed that the first-time Title X grantee, Obria Group, Inc. had yet to begin serving any patients despite an April 1, 2019 project start date. Has Obria Group Inc. begun serving patients since then, and if so, how many?

Response: Obria has started providing family planning services. Title X grantees provide reports detailing the services provided under their grants retrospectively on a calendar year basis. Accordingly, the first complete reporting of the clients served and the family planning services provided is due in January 2020.

3. During that same briefing you indicated anticipating it taking up to nine months for first-time Title X projects to even begin serving Title X patients. Given this acknowledged lag for first-time Title X grantees to begin serving patients, for both Obria Group, Inc's current project area, as well as if/when new first-time grantees are awarded, has OPA assessed the following and if not, why?

    a. How many Title X-eligible patients will either experience a gap in their ability to access low or no-cost family planning services or face indefinite loss of access to such care?

    b. Which communities and regions will be hardest hit with such gaps or indefinite loss of services?

    c. How many unintended pregnancies and new HIV or other STI infections does OPA project will occur as a result of such gaps or loss of access to low or no-cost family planning services?

Response: It is not possible to address hypothetical situations. However, we look forward to receiving reports from grantees on clients served and services provided. Those reports will provide HHS with significant data.

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing on
"Protecting Title X and Safeguarding Quality Family Planning Care"

June 19, 2019

Ms. Catherine Glenn Foster, MA, JD,
President and Chief Executive Officer, Americans United for Life

The Honorable Cathy McMorris Rodgers

1. Title X of the Public Health Service Act provides family planning services to low income women. Today, there are approximately 4,000 Title X service sites in the United States, including state and county health departments, Community Health Centers, non-profit clinics and Planned Parenthoods. The Protect Life Rule ensures that taxpayer-funded family planning centers will serve their intended purpose—to help women receive comprehensive preventive health care while ensuring the separation of taxpayer funds from abortion services.

   Out of the 4000 Title X sites less than 500 are planned parenthoods. In my district alone there are 26 Federal Qualified Health Centers (FQHCs) compared to 4 Planned Parenthoods. So this change would only allow for an expansion of coverage to more locations, including all those 26 FQHCs, that don't offer abortions, as well as allowing faith based family planning centers to apply for grants, without "slashing access to women's healthcare." By opening the grantee process and allowing for religious protections, this will actually expand preventative healthcare services for more providers to receive funding and provide additional preventative healthcare to low income communities.

   a. How do these centers—that are eligible for Title X funding under the Protect Life Rule—provide comprehensive and primary care to women?

Answer: While each grantee or subrecipient is not required to provide all Title X services, HHS will ensure that each Title X project offers a broad and complete range of Title X services.

   b. If abortions only make up a small percentage of services offered by Planned Parenthood it should be no problem for them to comply with this rule. If they, or organizations similar to them, were willing to comply with these simple rules would they continue to receive funding? So if they choose to prioritize abortion over preventative women's health care they would be denying their own access to this funding?

Answer: Yes. Any organization that has received a Title X grant—including a Planned Parenthood affiliate—is not automatically excluded or eliminated from Title X and will be able

to continue to receive funding provided that they comply with the Protect Life Rule. But if a grantee, or potential grantee—including a Planned Parenthood affiliate—chooses to prioritize abortion over Title X services, then they are choosing to opt out of receiving Title X grants and funding, and denying their own access to this funding.

c. Who will fill the gap if Planned Parenthood refuses to comply with the Protect Life Rule?

Answer: HHS has made the determination that even if Planned Parenthood or other Title X grantees choose to leave Title X, other grantees will likely fill their place. *See* 84 Fed. Reg. at 7780. Unlike the prior rule that required all Title X grantees to refer for abortion, under the Protect Life Rule, those who have a conscientious objection to abortion are no longer required to refer for abortion and will be able to apply for Title X grants. This expands the pool of potential applicants, such as Obria Group, which operates a chain of clinics throughout California, and applied for and was awarded Title X funds. *See Obria Grp., Inc. v. U.S. Dep't of Health & Hum. Servs.*, No. 19-905 (C.D. Cal.). We anticipate that there are other such groups who will do the same, and if Planned Parenthood refuses to comply with the Protect Life Rule (as they have threatened to do), other groups will enter the market and fill the gap.

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